MENTAL HYGIENE

VOL. XXXI JULY, 1947 NO. 3

EDITORIAL

MANY meetings and conventions are motivated by the opportunity they present for public education and publicity. It is refreshing, therefore, that the International Congress on Mental Health to be held in London in August, 1948, grows out of a spontaneous demand on the part of the profession, especially in Europe, for an exchange of new facts and experience and for stimulation after a long period of isolation and preoccupation with the issues of war.

It would be easy, in planning such a congress, to devote the program to those titles and topics that tend to be the most engaging. However, in this instance the congress itself is the culmination of a year or more of preparatory effort and, it is hoped, will be a prelude to succeeding years of progress directed toward the application of mental hygiene to world problems. The main topic is "Mental Health and World Citizenship." Between now and the time of the congress, commissions will be at work all over the world formulating reports on the essential elements of world citizenship, and these reports will provide the foundation for programs of the congress. The preparatory commissions will be composed of representatives of a number of disciplines related to mental hygiene—psychiatry, psychology, psychiatric social work, cultural anthropology, education, and so on. Attendance at the congress will take on value in proportion to the work a member devotes to these preparatory commissions. Information about organizing such a commission will be found in the memorandum by H. Edmund Bullis in the Notes and Comments section of this issue of MENTAL HYGIENE.

NEW OPPORTUNITIES FOR THE IMPROVEMENT OF MENTAL HOSPITALS*

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IN recent months our mental hospitals and particularly our state mental hospitals have been the object of serious charges in newspapers and magazines. Last May, Dr. Karl Bowman, in his Presidential Address before the American Psychiatric Association, called attention to the fact that these charges dealt with conditions well known to psychiatrists—conditions that the American Psychiatric Association and its members have been struggling for years to improve.

What are these charges?

1. Outworn, inadequate, and at times hazardous hospital buildings.
2. Overcrowding, neglect, and even abuse of patients.
3. Insufficient personnel at every level from attendant to physician.
4. Inadequately trained personnel.
5. Salaries, living conditions, and recreational facilities for attendants, nurses, social workers, and physicians at such a low level as to make impossible the recruitment of a sufficient number of personnel, let alone the improvement in their quality.

If these charges, when stripped of exaggeration or overdramatization, are in the main true, they constitute a serious indictment. Yes, an indictment—but an indictment against whom?

Certainly the patients are not to blame. The attendants, overworked, underpaid, and often ill-trained; the nurses, social workers, and doctors, working long hours with the most

*Presented before the Mental Hospital Section of the American Hospital Association at its Forty-eighth Annual Convention, Philadelphia, October 2, 1946.

difficult type of patient, frustrated in their therapeutic efforts by excessive case loads and by sheer lack of time—they have not caused, nor have they the power to remedy, this unhappy state of affairs.

We come, then, to the hospital superintendents—perhaps they are the guilty ones. If we could only find some one on whom to pin the blame!

Hospital superintendents are to-day receiving the lion's share of the blame. Is this justified? An honest appraisal, I believe, will show that the superintendents have protested, too often in vain, against inadequate buildings and budgets. They have shown—indeed, have had to show—great ingenuity in making wholly inadequate budgets cover the multitudinous and complex demands of a hospital for the mentally ill. It is true that some superintendents have become discouraged after repeated frustration, and it is also true that in some states, the professional requirements for the position of superintendent are inadequate. It is true that when funds and personnel are grossly lacking, a choice must be made as to which patients shall receive therapeutic preference—and it is natural and can be defended as good judgment to focus limited treatment and nursing efforts upon those patients most likely to recover. In an overcrowded, understaffed institution, this means that the most difficult and the most hopeless cases will suffer deprivation and, where attendants are untrained, abuse.

Superintendents as a group have worked consistently for the betterment of the state mental hospitals, but with inadequate support from either the public or the legislators. Now that the facts have come to light, should the superintendents be held responsible? Clearly, it has not been within their power, basically, to remedy the situation. The superintendent does not hold the purse strings. Perhaps I may be permitted to paraphrase Gilbert and Sullivan for this occasion and say, "Ah, taking one consideration with another, the superintendent's lot is *not* a happy one."

Well, then, if neither the professional staffs of the hospitals nor the superintendents are primarily responsible for the present unacceptable state of affairs, must we not lay the blame at the door of the state legislative bodies, for they indeed control the funds? In our democratic system, however, the legislature, both in theory and in fact, responds to the

will of the people. If the legislatures have not provided sufficiently for our state mental-hospital systems, we can only conclude that the will of the people in this regard has not been expressed—indeed, that the public has not been sufficiently acquainted with the needs of the mental hospitals. The legislators cannot be expected to take leadership successfully unless sustained by the public will.

Who, then, is to inform the public? We now find our inquiry completing the cycle, for the public looks to the press for information—and the press, when it informs the people, does so in true American style with full dramatic effect!

It is easy for me, who have never carried the responsibility for the administration of a mental hospital, to declare that the press and the magazine writers have on the whole done well to bring the deplorable conditions that exist to-day forcibly to the attention of the public. They have done well, for without an informed public there is no forseeable prospect of significant improvement.

If, as indeed appears to be the case, no individual or group in the hierarchy of the state mental-hospital system is primarily responsible for the present state of affairs, we must inquire, How did the state mental-hospital systems "get this way"? Do the causes apply uniquely to the state mental-hospital systems, or are they such as operate in other large public institutions?

It seems to be generally true that when large public institutions, whether federal or state, become inefficient, outworn, or no longer adequate to the purposes for which they were formed, those aware of the deficiencies are prone to withhold the facts from public notice, perhaps in the hope that the condition may be remedied from within, or to protect others who may not be wholly responsible. If the situation continues to deteriorate, the fear of public revulsion at the seriousness of the case is a further potent reason for discouraging publicity. From this point on a vicious cycle operates—the worse the state of the institution, the greater the pressure to avoid facing the issue or allowing public opinion to operate. Thus the basic faults and outworn standards from which the difficulties arise become more and more firmly entrenched within the system, and nothing short of a major operation gives promise of cure. At last the situation becomes intolerable—an

exposé occurs and may result in reform, but sometimes the exposé leads only to a semblance of reform and appeasement of the outraged public conscience.

One can trace this cycle of events in numerous instances in the past in our orphan asylums, in state penal and reform institutions, and in some of our educational systems.

We are now in such a cycle in our state mental-hospital systems, and we have witnessed the usual response to the exposé: first a denial, then an insistence that the evils have been exaggerated—they usually are exaggerated when an exposé becomes necessary—and finally, when the facts can no longer be denied, the assertion that these unhappy conditions have long existed and are well-known to every one, "why, all the fuss just now?" particularly when one can point to this or that improvement.

When deterioration actually has taken place in a system, such moves are the reactions of anxiety and as such are nearly always inefficient.

There is but one effective answer, but this answer takes boldness, courage, vigor, and sustained planning. This answer is to welcome exposure of the facts, boldly to state the facts, and to focus public attention upon the delays and obstacles to reform.

Even with strong public support and responsive state legislatures, however, there are aspects in the present picture that make early improvement exceedingly difficult. We are to-day desperately short both of buildings and of personnel. It takes time to build new hospitals and it takes time to train new personnel.

The shortage of personnel in every category will be especially difficult to remedy during the next five years because of the vigorous expansion of the Veterans Administration's hospital program—a program so extensive that it may well absorb all the new psychiatrists, social workers, clinical psychologists, psychiatric nurses, and attendants who are now available or likely to be trained during the next five years.

The Veterans Administration, now under an able and progressive leadership, has already inaugurated a training program for psychiatrists and for clinical psychologists, and is planning such a program for psychiatric nurses. This is all to the good and deserves high praise and full support. But this

enlightened activity on the part of the Veterans Administration throws into sharp contrast and accentuates the plight of the state mental hospitals. Not only are the salaries offered by the Veterans Administration at a higher level than in most state-hospital systems, but the opportunities in the Veterans Administration, under its new regulations for continued professional training and advancement, are such that, under the present system, it is hard to see how the state mental hospitals can compete successfully in recruiting new personnel.

It is for these reasons that I believe there is grave danger of progressive deterioration of the state mental-hospital systems, which, if unchecked during the next five years, will spell disaster for our patients and dynamite for the politicians.

Dr. George S. Stevenson, Medical Director of The National Committee for Mental Hygiene, in unpublished remarks made before a round-table discussion at the American Psychiatric Association meeting last May, expressed a similar warning.

We are indeed facing a crisis in the state mental-hospital systems about which the public, the legislators, and the governors of the states have a right—in fact, a duty—to be informed.

The only hope of averting disaster lies in a full knowledge of the facts in a program based upon the needs of the patients, and in early, farsighted, and decisive action by the state legislature, supported by an informed and aroused public.

I have referred to the Veterans Administration. Only a short time ago the medical department of this organization was in a most serious condition of stagnation: isolation of hospitals, overcrowding of patients, inadequate and poorly trained personnel, no opportunity or incentive for professional training. Many despaired of the possibility of improvement.

In view of the large proportions of psychiatric patients in the Veterans Administration hospitals, the situation was in many respects analogous to that now facing the state mental hospitals.

What seemed to be impossible has been accomplished. The Veterans Administration to-day, under the splendid leadership of General Bradley and at the insistence by General Hawley that the highest medical standards shall prevail, has become a shining example of what can be done to change an outworn program, when the will of the people is aroused.

Some of the writers who to-day are crusading for reform of our state mental hospitals led the campaign to reform the Veterans Administration. These writers deserve our coöperative support, for they represent a vital channel of communication with the public; and if the public is to take intelligent action, it must be told the truth.

Only a sustained effort on the part of the public, the various health and welfare agencies, the press, the legislators, The National Committee for Mental Hygiene and the state mental-hygiene societies, the Psychiatric Foundation, the National Mental Health Foundation, and the professional organizations representing the hospital personnel can lead to a successful outcome.

The press has awakened us from our lethargy—a rude awakening, perhaps, but the rudeness of the awakening is often in proportion to the depth of the somnolence.

Instead of evasive and defensive action, let us take the offensive and lead the battle. Let each superintendent, within the limitations of his particular situation, boldly and progressively inform his community of those basic needs of his patients for which he is now unable to provide. Let him be vigorous and specific in his statement of those needs, so that no leader in his community can remain in ignorance of them. Then the true potentiality of full publicity in the press will become evident, for under such circumstances, publicity cannot become an exposé. The community and the legislators will not be shocked, because the facts will already have been widely publicized. The publicity will now be in support of the superintendent, and in support of the state commissioner, and will become focused on the adequacy of the bills before the state legislatures.

It must be recognized that the vigorous policy here suggested for the superintendent will not always be free from the danger that the hospital inadequacies he reveals may be used as a weapon against him. This is a genuine danger in some cases. Is the risk as great, however, when the superintendent takes the initiative in informing the public as when the press "breaks" the story in an attack upon him? I believe that the existence of bad conditions in a hospital is always a danger to the superintendent, but to hide such conditions is far more dangerous than to face them openly.

The National Committee for Mental Hygiene has already signified its readiness to lend support to this offensive, as indicated by two resolutions recently passed by the board of directors.

1. "RESOLVED, that The National Committee for Mental Hygiene learns with satisfaction that the American Psychiatric Association has established improved standards for mental hospitals and mental clinics and will lend every support to all hospital superintendents, state officials, and others in authority, to use all means in their power to see that these standards are adopted and maintained in their institutions."
2. "RESOLVED, that The National Committee for Mental Hygiene will encourage and actively support the efforts of superintendents of mental hospitals and of commissioners of mental hygiene and other local or state officials to communicate with the community regarding the needs of their hospital and of the patients under their care."

According to Bureau of the Census figures, during 1943 there were over 100,000 new admissions to state hospitals and over 67,000 discharges.

Using these figures, we may estimate conservatively that during the next ten years there will be admitted to our state hospitals over 1,000,000 new patients, and that more than 670,000 patients will have been discharged back again into our communities. The extent of this flow of humanity in and out of our state hospitals has not been sufficiently emphasized. Sojourn in a mental hospital is for the majority of patients transient, a matter of months, not years. The majority of the million new patients anticipated during the next ten years will spend by far the greater part of their lives, not in the mental hospital, but back in the community. What happens to these sick people during their temporary residence in a mental hospital should be of great concern to the community to which the majority of them will soon return.

What proportion of these patients discharged will be readmitted needlessly for lack of continuity of care after discharge —a continuity of care now prevented both by the physical and, even more, by the attitudinal isolation of the state mental hospital? What proportion of these discharged patients will carry back into their communities maladjustments, hatreds, and feelings of aggression accentuated by their experience in our state mental hospitals?

The principals of good psychiatry and of mental hygiene, like charity, should begin at home. Home in this instance is

represented by the state mental hospital. What kind of home is it? The professional and attendant staff constitute the family. The superintendent is the father figure. The patients are the guests—perhaps unwilling guests, but nevertheless guests—not slaves. Perhaps a truer analogy would be to consider the patients as children—problem children in the home.

Is the superintendent a good father? Does he give dignity to the human values of every member of the household? Are conditions in the home and the opportunity for recreation as well as work such as to make a happy home possible?

Unless the various echelons of the staff, from superintendent to attendant, can develop good human relationships with one another, what chance is there for constructive human relationships between staff and patients?

The hospital exists for the patients—to provide for their care, protection, and treatment.

Our basic consideration, then, must be: What are the needs of the patient? In so far as a hospital or hospital system fails to provide for the basic needs of patients, the hospital fails in its main function. All other considerations are of secondary importance.

Reasonable salaries, working, living, and recreational facilities for every member of the staff, professional competence, and modern principles of treatment, form the essential framework. If we focus our attention and the public's attention upon the patient and his basic needs, we will be focusing upon the only bench mark by which the success or failure of the hospital can be measured.

I note in a recent report in the *New York Times* the following statement by Alvin E. Dodd, President of the American Management Association: "Apparently management has come to realize that if it spends as much time and energy developing the full potential of individual employes as it has devoted in the past to utilization of technical knowledge and machinery, it will realize tremendous sources of productive power." The report goes on to say: "American business is taking concrete steps to insure that its management in all echelons from top executives to office and sales managers and plant foremen is thoroughly conversant with intelligent and enlightened human relations policies."

These are the principles of mental hygiene. They arise from modern psychiatric insights into human nature and interpersonal relations. It would be ironical indeed if our psychiatric institutions should be backward in adopting them.

I have tried to paint a realistic picture of the seriousness of the problems facing the state mental hospitals. In the case of a psychiatric patient, it is often necessary for the symptoms to get more severe before the patient will seek aid. Perhaps our sick mental hospital systems had to reach their present degree of illness before recovery could set in. In spite of the gravity of the present situation—indeed, partly because of it—there is an opportunity now more than ever before to make the necessary changes.

The psychiatric casualties among our troops, the great number of men rejected by Selective Service for psychiatric disabilities, and the wide recognition that emotional problems play a major rôle in many of the bodily disturbances that the physician is called upon to treat—these and other factors have combined to bring forcibly to the attention of the public the widespread nature of emotional and mental disturbances and the value both to the individual and to the community of sound emotional as well as bodily growth and maturation.

The public interest has been further stimulated by a number of novels and moving pictures dealing with psychiatric problems. The stage is set for change. Now is the time for all concerned to take the offensive in a vigorous and sustained "combined operations."

THE NATIONAL MENTAL HEALTH ACT

HOW IT CAN OPERATE TO MEET A NATIONAL PROBLEM*

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A YEAR ago, at the Thirty-Sixth Annual Meeting of The National Committee for Mental Hygiene, I presented a blueprint for mental health[1] in which were outlined the objectives and plans of the United States Public Health Service for a nation-wide mental-health program. To-day, thanks to the unstinting efforts of the National Committee and other lay and professional groups interested in mental hygiene, those plans are about to be realized. On July 3, 1946, with the signing of the National Mental Health Act by President Truman, there has been authorized for the first time in our history a long-range, comprehensive program for the improvement of the mental health of our people. At long last this country has an instrument for dealing on a broad scale with one of our major public-health problems—mental illness.

To all of us who are familiar with the many obstacles that have long impeded the progress of the mental-hygiene movement, the passage of the National Mental Health Act is particularly encouraging. Mistaken ideas of what mental hygiene is and does; controversy within our own ranks; deep-rooted prejudices against the whole subject; acute deficiencies in personnel, facilities, knowledge, and funds — all have combined to permit mental illness to reach grave and threatening proportions.

Statistics point with monotonous regularity to our failure to cope with the problem in the past.

* Presented at the Thirty-seventh Annual Meeting of The National Committee for Mental Hygiene, New York City, October 31, 1946.

[1] See "Psychiatric Plans of the United States Public Health Service," by Robert N. Felix. MENTAL HYGIENE, Vol. 30, pp. 381-89, July, 1946.

> By conservative estimate more than eight million Americans are suffering from some form of mental or nervous illness.
>
> More than half of all hospital beds in the United States are occupied by mental patients.
>
> More men received medical discharges from the armed forces for neuropsychiatric disorders than for any other reason.

And so the facts and figures accumulate to form a national picture that must give us serious concern.

We have long since learned that the problem can never be solved simply by building more institutions for those persons whose abnormal behavior can no longer be ignored or neglected. Our goal must be not merely to press for better care of those mentally ill persons for whom we have failed to provide adequate treatment in time. Rather, we must adopt the positive aim of utilizing our talents and energies to prevent such illnesses and to improve the mental health of the nation.

Public and private organizations and individuals have made great contributions to the promotion of good mental health, it is true. But these efforts have not been coördinated nor has there been any uniformity in the progress made. Under the National Mental Health Act, the country can at last go forward on a united front.

The enactment of this legislation is of special significance because it represents the acceptance by our federal government of greatly increased responsibilities for combating mental illness. The importance of this acceptance cannot be overestimated. It means that the problems of mental illness have been recognized as analagous to those of cancer, venereal disease, tuberculosis, and public health in general, and that they require comparable interest and activity on the part of the federal government.

The fact that federal legislation has been passed to combat this problem does not mean that the responsibility of the individual states has been lessened in any degree. Quite the contrary. The program can succeed only by the type of teamwork that has proved so effective in other fields of public health — coöperation and active participation by the federal

government, the states, the communities, and the public and private professional and lay organizations. For the states that have made progress in setting up effective programs of mental hygiene, this law should make possible further development; in the other states, it is now possible to make a beginning in this direction. It should fortify and enrich state plans and help provide the tools with which they can be carried out.

The National Mental Health Act is aimed at bringing about direct action in three interrelated fields: increased research in the field of nervous and mental diseases; the training of urgently needed personnel; and the improvement and expansion of community mental-health services.

Research.— The Public Health Service is authorized by this legislation to foster, through grants-in-aid, the expansion and development of research into the causes, diagnosis, methods of treatment, and prevention of nervous and mental disorders. In the past, research in the field of mental hygiene has lagged far behind investigations in other fields of medical science. Our knowledge is limited, and many of our conclusions rest on slender foundations. We still have much to learn about the etiology of various mental illnesses. If, for example, we knew the cause or causes of just one of the psychiatric disorders — schizophrenia — we could more rationally and effectively treat, and perhaps eventually lower the incidence of, a form of mental disease that accounts for about 45 per cent of the population of mental hospitals.

Under the National Mental Health Act, research can be accomplished in three ways. First, it can be supported by grants-in-aid to universities, hospitals, laboratories, and other public or private institutions, and to individuals. Under this provision, research projects must be approved by the National Advisory Mental Health Council. The council consists of a group of six individuals, selected without regard to civil-service laws, from leading medical and scientific authorities who are outstanding in the study, diagnosis, or treatment of nervous and mental disorders. This authority greatly multiplies the amount of research with which the service can assist and should do much to stimulate projects that would otherwise remain only in the idea stage.

Research is thought of in the broadest possible sense. There is much in the fields of anatomy, physiology, and chemistry, not only of the nervous system, but of other systems as well, that must be learned if we are to understand many of the phenomena of psychiatric and neurological disorders.

In addition to basic research, investigations must include intensive clinical studies of psychiatric disorders in order to discover more about the etiology and nature of these disorders, to develop better diagnostic methods, and, on the basis of these findings, to formulate rational programs of treatment. Schizophrenia can be used here also as an example of what is meant. We classically divide this illness into several subgroups, but the wide differences existing among the symptoms of these respective types indicate that we may be dealing with a collection of diseases that we have lumped under one heading because of certain common symptoms.

Research programs must not be passed by because they appear to have only an indirect bearing on clinical psychiatry and neurology. In this connection a lesson can be learned from the story of the development of the atomic bomb. Many vital contributions to this project were the result of investigations that at the time they were carried on seemed to have no direct bearing upon the subject of nuclear fission.

There will be no pressure to enter only on projects that will yield results within a short period of time. Long-range studies — such as the rôle played by heredity in mental illness — from which no specific results can be looked for in any one generation, can be developed and maintained as well as the short-range projects.

No comprehensive program of psychiatric research can fail to take into consideration sociologic, anthropologic, and similar investigations. Environmental influences, complex as they are, must be thoroughly understood if we are to gain a well-rounded concept of human behavior.

Second, the act authorizes the establishment of a research and training center in the Washington area, to be known as the National Institute of Mental Health, in which much-needed research will be carried on by a full-time staff and advanced students. This institute will be a part of the research facilities and organization of the United States Public Health Service.

Here coördinated studies will be conducted not only in the basic sciences, but also in those clinical and environmental fields that bear upon the problems of mental health.

For clinical observation, the institute will include a hospital unit, with patients selected on the basis of the studies being conducted. The hospital will be completely equipped and will serve also as a model training unit.

The central institute will be a place where unusual and complicated problems can be brought — problems that require special facilities for their solution. It is not intended that the institute control or supplant psychiatric research elsewhere. Instead, it is conceived of as a center that will be in a position to give leadership to investigative work that needs to be developed throughout the country.

Third, the law provides for the appointment of research fellows in the various sciences that may reasonably be expected to contribute to the solution of the many enigmas in the realm of mental illness. Until the institute is available, all fellows will have to affiliate themselves with a university, a foundation, or some other type of research center. When the institute is complete, some fellows may elect to pursue their work at this center. The fellowship program will encourage capable students to engage in research activities and will make it financially possible for them to contribute to the various sciences, while enhancing their own value and professional prestige.

Training. — The greatest current barrier to the provision of adequate facilities and to the development of mental-health programs as a whole is the lack of sufficient and well-trained personnel. It is futile to consider the establishment of clinics or the expansion of mental hospitals unless trained personnel are available to staff them. It is estimated that, to meet our minimum needs, we need at least four times as many psychiatrists as we have in the United States to-day. Speaking in terms of public service only, we have not more than one-fourth the needed number of clinical psychologists, one-fourth the psychiatric nurses, one-fifth the psychiatric social workers. In other types of personnel, such as attendants, the needs are just as pressing.

Before mental-health programs can make any real head-

way, trained personnel must be available in all these categories. At the present rate of training, however, we are doing little better than keeping abreast of attrition.

To promote training and instruction in the field of mental health, the act authorizes the Public Health Service to assist, by means of grants-in-aid, public and non-profit institutions in improving or developing their training facilities. Grants-in-aid may not be used for the construction of buildings, however. In this way, institutions that already provide training in mental health can expand to accommodate more students; and potential training centers — in hospitals, medical schools, and other schools — can be developed.

We could go a long way in our attack upon the problem of providing adequate psychiatric training through grants-in-aid to medical schools. Such grants would have a threefold purpose: (1) to provide adequate postgraduate training for those who elect to specialize in the field; (2) to improve the undergraduate psychiatric training of all medical students, which would mean those who will enter the general practice of medicine or one of the specialty fields; and (3) to interest more medical students in the field of psychiatry as a specialty.

Postgraduate education of psychiatrists is an important part of the total problem of post-war medical education. Many hospitals and clinics, with some assistance, could be developed into excellent postgraduate training centers if they could get properly trained instructors. Here is the bottle neck in psychiatric education at all levels — lack of enough adequately and properly trained teachers. The first step that must be taken in a long-range program is to train enough psychiatric teachers to meet the needs both of graduate and of undergraduate instruction, not only in psychiatry, but also in the ancillary fields. As teachers become available, training centers can be developed to meet the current deficit in personnel and to insure an adequate supply in the future. The establishment in connection with all medical schools of adequate facilities for training competent specialists in psychiatry would also provide centers for clinical training of the other categories of mental-health personnel.

With more adequate facilities, undergraduate teaching of psychiatry can be improved. At the present time not over

half of the medical schools in the country present psychiatry to the student in a satisfactory manner. The medical student needs to accept psychiatry as an integral part of medicine, with which he must be familiar if he is properly to evaluate and treat his patients. Upon graduation, the medical student should have acquired an understanding and appreciation of the principals and practice of psychiatry equivalent to his understanding and appreciation of the principles and practice of surgery. He should be equally able to apply the methods of treatment best applicable in each and to recognize his limitations, which are inevitable without further special training. Psychiatrists, on the other hand, must recognize that there are many emotional disturbances that can be treated as well, if not better, by the general practitioner. Just as it does not require certification by the American Board of Surgery to reduce a dislocated shoulder, neither does it require certification by the American Board of Psychiatry and Neurology to reduce many simple dislocations of our so-called normal emotional life.

Until psychiatry is presented in the proper light, it will be difficult to stimulate the interest of the medical student. It takes a hardy soul to walk the wards where mental patients are housed, to see the overwhelming handicaps under which psychiatry operates in our large, overcrowded, understaffed public institutions, and still feel that psychiatry has an application to the everyday practice of medicine. The subject must be presented in a way that the student will understand and find challenging.

The improved psychiatric training of the general medical practitioner is, then, a very important goal of the authorized training program. In the past, too many physicians have felt that they knew little about mental diseases. This attitude, which was reflected in their practice, can be blamed to a great extent on those responsible for the physicians' training.

During the war, however, many doctors were confronted with undeniable evidence of the influence of emotional disturbances upon bodily functions. As a result, many doctors have become greatly interested in the psychological aspects of somatic medicine and eager to learn more about psychiatric methods of treatment. Lieutenant-Colonel Roy Grinker and

Major John Spiegel of the Army Air Forces, in their book, *Men Under Stress,* point out:

> "We have trained many general medical men, worldly wise and in their early thirties, who have had experience overseas with men in combat and who were impressed with the frequency of emotional factors in the etiology of somatic symptoms. Most of them planned to return to their own specialties or to general practices after the war. But they will not return as they left; they will have a new understanding of the total personalities of patients whose diseases alone they had been accustomed to treat. One young surgeon stated that he learned how often he had operated on patients unnecessarily. Another realized how important it was for him to understand his patients' emotions during their postoperative care. All of these men will be foci of educational stimuli as they disperse throughout the country."[1]

In one state recently the physicians were circularized by their state medical society to learn how many of their patients, in their estimation, came to them with conditions that were either caused by or aggravated by emotional difficulties. These physicians — general practitioners — estimated that 60 per cent of the patients who came to their offices fell into this category.

To think that we can provide psychiatrists to take care of that number of patients seems at this time to be not only an almost impossible dream, but an impractical one. Properly trained, the attending physician could deal competently with the majority of mild cases of emotional disturbances as part of the total clinical picture with which he perforce must deal. In order most effectively to bring this to pass, the training must begin in the first year of medical school and continue through internship at least. At a meeting of consultants in mental hygiene of the United States Public Health Service, the following conclusions were reached concerning the objectives of undergraduate instruction in medical schools[2]:

1. To teach fundamental concepts of human behavior, motivation, gratification, and conflict.
2. To teach the emotional experiences of sick people. The student should also be made aware of his own emotional relationship to his patient.

[1] See *Men Under Stress,* by Roy R. Grinker and John P. Spiegel. Philadelphia: P. Blakiston Sons, 1945. pp. 429-30.

[2] See Public Health Reports, United States Public Health Service, Vol. 61, No. 26, June 28, 1946.

3. To teach that emotional disturbances as well as toxic, metabolic, or physical factors produce illness.
4. To teach an understanding of illness associated with or caused by disturbed cerebral metabolism.
5. To teach some classificatory knowledge of psychiatric diagnostic syndromes.
6. To teach useful diagnostic and interviewing techniques.
7. To assist the student in gaining insight into his own personality make-up and particularly his emotional biases, prejudices, and blind spots, preferably through intimate contact with the psychiatric teacher.
8. To give a reasonable concept of methods of psychotherapy and an appreciation of his own potentialities and limitations in this regard.

If the psychiatric curricula of medical schools are developed around these objectives, and properly presented, it is inevitable that more students will become interested in psychiatry as a specialty than has been true in the past.

For those who wish to specialize in psychiatry — and they should be selected on the basis of demonstrated genuine ability and a sincere interest in the field — the graduate training should equip the student with a broad background in the humanities and the social sciences as well as with a thorough grounding in the biological sciences and the special field of psychiatry.

In order to assist those persons found qualified for graduate training, the National Mental Health Act authorizes the Public Health Service to establish stipends for such training. These stipends will be available not only to students in the field of psychiatry, but in the ancillary fields as well. The number of trainees who may be assisted in this way will be determined by the National Advisory Mental Health Council.

Community Mental-Health Services. — The objective of increased research and personnel training is the improvement and expansion of mental-health services. The act authorizes an annual appropriation up to $10,000,000 for grants-in-aid to states for the development of mental-health programs at the community level, and for demonstrations to be set up by the United States Public Health Service, upon request of the

states, where the demonstration of proper standards and procedures will tend to raise the level of treatment both in hospitals and in out-patient clinics. Demonstrations will serve as a valuable method of inaugurating state programs where existing organization and facilities are absent or at a minimum.

The importance of the grant-in-aid program authorized by the National Mental Health Act cannot be overemphasized. It has been estimated by The National Committee for Mental Hygiene that in the entire country only about one-fifth of the needed clinic services are provided, and those that are available are for the most part concentrated in the larger population centers. There are fifteen states that provide no mental-hygiene services whatsoever. The act will make it at last possible to remedy this situation.

Grants to states will be made on the basis of the extent of the state's mental-health problem, the population of the state, and the state's financial ability to meet its own needs. The state mental-health authority will be required to submit plans that meet definite standards, and to maintain those standards in order to qualify for continued assistance.

The Public Health Service feels that it is to the advantage of the patients, the community, and the physicians themselves if the mental-health program is completely integrated into the general medical program of the community. If out-patient clinical facilities are available, psychiatric facilities should be woven into them. An individual should be able to go to the same clinical facility whether he has an ulcer of the stomach or a gastric neurosis. The fact that the mental-health facilities were not segregated would tend to remove in the eyes of the community much of the stigma that is still attached to any form of mental illness — and there would be less resistance to seeking psychiatric aid in the early stage of illness.

As these facilities are developed in the community and as they are accepted and recognized as being of value, a logical and effective job of educating the public is being done. People see mental hygiene in action; they learn that cases can be found early and cured or very materially helped; they begin to think of mental illness as they would of another ailment. The psychiatrist himself feels an integral part of the medical

organization, and the other physicians more readily accept psychiatry as an important and contributing member of the medical family. The mutual interchange of knowledge and viewpoints growing out of such coördination *would* benefit both the psychiatrist and the other specialists.

Similarly, there should be facilities in general hospitals where patients suffering from many types of emotional disturbances could be treated. For many psychiatric patients, it should not be necessary to go to an institution separate and apart from that providing other medical care.

In the general hospital that provides psychiatric facilities, the psychiatrist would be an important part of the staff — not merely a consultant called in when it is believed that a patient is suffering from a psychological disturbance. He would make his rounds in the hospital as do his colleagues in other specialties, meet them there, and discuss medical problems with them. He would come to be accepted as a physician of equal standing and skill in the field of medicine with the internist, the surgeon, and the pediatrician.

Only when the position of psychiatry is firmly established in the family of medicine can mental hygiene be fully developed — either nationally or in the individual states.

The states must begin now to play their part in a national mental-health program. Those that have not already done so can lay the groundwork for a sound program within their own borders by carefully surveying their assets and needs and by making long-range plans which they can start developing now. These plans should provide for the training of personnel and the establishment of both inpatient and outpatient facilities necessary to meet the needs of the state. In such a favorable environment, worth-while programs of research would inevitably develop, thus contributing to the sum of the knowledge in the field.

The tremendous importance of the cumulative success of such individual efforts is underscored by Dr. G. B. Chisholm, Deputy Minister of Health of the Dominion of Canada and Executive Secretary of the Interim Commission of the new World Health Organization, in his William Alanson White Memorial Lecture. To quote Dr. Chisholm in part:

"We have never had a really peaceful society in the world, but only short interludes of forgetting and then frantic preparation between wars. Can the world learn to live at peace? . . . . If we cannot, the job will be left to what survivors there may be after the next war, or to intellectually more honest and braver people who may get a chance some generations later. With the other human sciences, psychiatry must now decide what is to be the immediate future of the human race. No one else can. And this is the prime responsibility of psychiatry."

THE STATES' OPPORTUNITY IN MENTAL HYGIENE*

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FIFTEEN years ago the president of the Metropolitan Life Insurance Company made the statement that when leaders in the fight for improved mental health could prove they were making real progress, comparable to the splendid record of decrease in the number of tuberculosis cases and improving expectancy of recovery for tuberculosis patients in this country, then the insurance companies, business corporations, the general public, and the government would provide adequate finances to support our mental-health efforts.

Unfortunately, mental-health statistics each year are more alarming, and this financial support has never been realized. The National Mental Health Act, when implemented by an appropriation bill to put it into effect, will be the first step toward adequate financial support to train personnel, to stimulate research, and to encourage mental-health workers in their most difficult and little-appreciated field.

The mental-health battle front in every state can be mapped with a fair degree of accuracy. It is always dramatic to present the magnitude of the problem confronting us. However, when we outline the states' opportunity and indicate the strategy we will use and the forces and the equipment we have ready to put into action at the mental-health battle front, the dramatic note becomes tragic, because the old story is repeated—"too little, too late."

The next five years will undoubtedly be the most critical years faced by state mental institutions since World War I. In spite of the erection of additional Veterans Administration mental hospitals to take care of the psychiatric and neurological casualties of the late war, the indications are that our state institutions will have their greatest populations in his-

* Presented at the Thirty-seventh Annual Meeting of The National Committee for Mental Hygiene, New York City, October 31, 1946.

tory. To handle these increased loads, it is evident that we are going to be faced with a decided shortage in all types of trained hospital personnel. Unless miraculous changes are brought about, our deplorable hospital standards in too many mental hospitals throughout the country will not be improved.

Many believe that in the years just ahead there will be a decided trend toward cutting down the cost of state government, at a time when our hospital-operation expenses are going up rapidly. Budgetary difficulties, personnel problems, construction material, and food shortages, union controversies, increased hospital loads, competition with higher salaries paid by the Veterans Administration — it is no wonder that only 60 out of over 900 psychiatrists leaving army or navy service indicated any interest in obtaining state mental-hospital posts.

Public Law No. 725 — the Hospital Survey and Construction Act — has been passed by Congress. As a result of this act, the federal government will pay one-third of the cost of building and equipping hospital projects that have been approved by the state advisory councils appointed by the various governors, up to the limit of funds authorized each state. Seventy-five million dollars a year for five years will be available for this purpose. This amounts to $375,000,000 for the five-year period, which, when matched with the $750,000,000 from the states, counties, municipalities, and non-profit organizations, will provide a hospital building fund of $1,125,000,000 during the next five years.

According to testimony given at hearings on this bill before it was passed, these funds would provide for 914,629 hospital beds, of which 308,486 were needed in mental hospitals.

The funds would also provide 4,500 new public-health centers, principally for rural communities. In addition to funds already mentioned, the bill provides $3,000,000 for surveys to be made in the various states to determine hospital needs. Generally speaking, this survey money has been turned over to the various state departments of public health and surveys have already been made or are in progress.

Some states have already forwarded their first projects to Washington for approval. I am very sorry to state that so far very little indication has been given that funds for

psychiatric wards in general hospitals or mental-hospital beds of any type are being requested. Every one of us should make it our business to find out who is on our state advisory council. We should insist that the governor or legislature appoint one member representing our mental-hospital interests.

The interest of the general-hospital leaders and the public-health departments of the various states is naturally in the direction of improved general-hospital facilities and increase in the number of rural hospitals and health centers. This attitude, to my mind, is logical and satisfactory, provided that in all these health centers and in many of the general hospitals, psychiatric and neurological facilities are provided. In the Congressional hearings, it was brought out that one-third of the beds to be made available by this Hospital Construction Act were badly needed for mental hospitals. We should strive to obtain one out of three beds for mental patients, as was the intent of Congress. To obtain them, we must influence the various advisory councils appointed by our governors.

In Delaware we pay .99 per cent of all federal income; consequently, we shall pay, over the five-year period, approximately $3,740,000 toward the cost of this Hospital Construction Bill. Of this amount, Delaware will receive back $445,000 in state-aid grants over the same period — less than 12 per cent. I mention this distribution, which we in Delaware consider unfair, only because it will have an unfortunate effect when the appropriation bill to implement the National Mental Health Act comes up before Congress next session. To help prevent losing support of the higher-per-capita-income states, I would suggest that the United States Public Health Service allow a more reasonable percentage of state-aid funds to be left in the larger income states. For example, in the distribution of federal tuberculosis funds, Delaware has made no complaint, for 44 per cent of Delaware federal support of tuberculosis funds are left in Delaware.

In outlining the mental-health opportunities that confront the various states, I have to draw on my experience in Delaware, a small, high-per-capita-income state which is fortunate in having a mental hospital and out-patient-clinic arrangements of comparably high standards.

Construction. — Delaware, in common with other states, has been unable during the war years to build badly needed additional mental-hospital facilities, and could see no opportunity of adding the necessary number of beds within the next several years. After many months of successful negotiating, Fort duPont — a surplus regular army post, conservatively valued at over $3,000,000 — was turned over to the state of Delaware at no cost and put under the supervision of Dr. M. A. Tarumianz, our alert, far-visioned state-hospital superintendent. On this post are a hospital administration building, many barracks that can be changed into hospital buildings, 37 officers' quarters, storage buildings, splendid utilities arrangements, and so on. These facilities, which are about ten miles from the mental hospital, are going to be known as the Delaware State Health and Welfare Center. Within the next few months, the following mental-hygiene services will be available there:

1. A department for the care and treatment of children between the ages of five and sixteen years who are either seriously maladjusted or mentally ill and who are amenable to modern care and treatment, and of other types of problem children who require careful study and the psychiatric approach (100 beds).
2. A department for epileptics without psychoses who require adequate study, thus eliminating the assignment of such cases to our colony for the feebleminded (100 beds).
3. A department for aged persons who are bedridden, but without frank psychoses, who need only nursing care and who now occupy badly needed space at the state hospital (120 beds).
4. A department for men and women of all ages who suffer from alcoholism without psychosis, either acute or chronic (75 beds). At present there are only a few states that have facilities for non-psychotic alcoholics.

Some of the officers' quarters at Fort duPont will be made available to staff members of the state hospital, thus alleviating a serious housing shortage. The almost ready-made facilities at Fort duPont will make unnecessary at this time

the planned expansion of the state hospital, thus saving the state well over $1,000,000.

There are hundreds of surplus army and navy posts, camps, and stations throughout the United States. Perhaps some other states may help solve their mental-hospital housing program in the manner just outlined.

Hospital Funding. — In Delaware we believe that the families of all patients should pay something every week toward the support of their relatives at the state hospital. This idea is tactfully explained to each family and has worked out most satisfactorily. At present, 26 per cent of the cost of maintenance of all patients in our state hospital comes from the patients' families in weekly sums ranging from 50c. to $45.50. Dr. Tarumianz hopes within the next five years to secure 50 per cent of the cost of maintenance from this source. This is about the same percentage of support that the average general hospital receives from patients. Patients' families are more coöperative and better appreciate the services of the state hospital when they pay toward the cost of hospital care.

Since September, 1946, the cost of mental illness has been incorporated in the Delaware Blue Cross Hospital Service Plan. Prior to that date, the Blue Cross Plan recognized only neuroses and maladjustments. To encourage early diagnosis and treatment, members of the plan who show symptoms of mental illness are sent to the state hospital for observation and the state is reimbursed by the Blue Cross as follows: $9 for the first day; $6.50 to $7.50 for the next twenty-nine days; and $3 for the next thirty days. Delaware is one of the three states in which the Blue Cross includes mental illness.

The Veterans Administration reimburses the Delaware State Hospital at the rate of $5 per day for its patients.

Decreasing the State Hospital Load. — In every state we should be working strenuously to sell the medical profession, the boards of directors of general hospitals, and the general public the idea that every general hospital should have psychiatric beds or psychiatric wards for short-time-treatment cases, only those who need extended treatment being transferred to state hospitals.

In localities in which there are few psychiatrists, medical

personnel from the state hospitals should be allowed to accept part-time appointments, as psychiatric consultants on general-hospital staffs. In turn, selected practitioners and specialists from the general-hospital staffs should be given part-time compensation for serving on the mental-hospital staff. In Delaware we have found that opthalmologists, endocrinologists, and other specialists greatly improve the services of our state hospital by holding clinics and at the same time take a considerable load off the physicians and the mental-hospital staff. This interchange of medical services and the development of psychiatric facilities in general hospitals is the best way I know of to bring the medical profession and the general hospitals within states into closer coöperation with our state mental hospitals.

Adequate Nursing Personnel. — In Delaware we have affiliated training arrangements with every general hospital in the state whereby nurses, before graduating, have to take three-months training in our state hospital. At all times we have these young women at the hospital, and they have proved invaluable. Dr. Tarumianz has built up over the years an excellent training course. Not only does this help solve the problem of shortage of nurses, but, more important, every nurse who graduates is familiar with the state-hospital set-up, is conversant with psychiatric problems, and is more competent to serve nervous and mentally ill persons.

Adequate Psychiatric Personnel.—To secure adequate psychiatric personnel, most state mental hospitals must pay higher compensation to psychiatric and other professional personnel so as to compete with the Veterans Administration hospitals and the army and navy hospitals. One 400-bed general hospital with which I am familiar has four members of its medical staff drawing $15,000 or more annually from the hospital.

In Delaware we, in common with the other states, are suffering from a shortage of psychiatrists, psychologists, and psychiatric social workers. I am quite sure that our difficulties in this regard would be largely solved if we had as effective a training program for this type of personnel as we have for nurses. We are handicapped because we have no medical college in our state. However, we hope to work out plans

whereby our state hospital will become affiliated with one of the leading medical colleges in Pennsylvania; and within a few years, we expect to build up a creditable training program for psychiatrists, psychologists, and psychiatric social workers.

In addition to our state mental hospital, we have, as training facilities for this personnel, our traveling mental-hygiene clinics and our new state health and welfare center.

The mental institutions in New York, Chicago, Philadelphia, Boston, and other cities in which adequate training and research opportunities are offered, are faced with no problem in obtaining psychiatric staff. In the future, state hospitals that fail to offer worth-while training facilities will have to be content with understaffed and unambitious personnel.

Psychiatric and other professional workers will not consider appointments at certain state hospitals because of inadequate living accommodations for themselves and their families. In these days of almost universal housing shortages, adequate housing attracts personnel. Professional personnel, before accepting state-hospital appointments, are inclined to compare working hours and vacation plans with Veterans Administration hospitals and other agencies.

National Mental Health Act training grants should stimulate many states to develop adequate programs for professional training, to the end that larger numbers of alert young medical, nursing, psychological, and social-work personnel may be attracted to state-hospital service.

Attendants. — Every state is facing the serious problem of not being able to obtain attendants. When prospective attendants have the opportunity of joining the "52-20 Club" and receiving $20 weekly unemployment compensation, it is not surprising that they are not interested in working as hospital attendants for $85 to $145 a month, even though they receive in addition their food and living accommodations.

A proper training program, with much higher pay for those trained, might help solve the problem. High-school graduates might be given a two-years training course to become nurses' aides. During training they should receive about $30 a week, uniforms, board, and textbooks Upon graduation, they should have the same type of salary that nurses have now. More of

the nurses in our state mental hospitals should become supervisors with more pay if this plan were worked out.

Changes in Mental-Hospital Procedures. — We must use our ingenuity and imagination in working out decided improvements in our present state-hospital systems. The following three trends are steps in the right direction:

1. Extension of psychiatric services in the majority of general hospitals.
2. Improving and extending the out-patient mental-hygiene-clinic services of our hospitals so that all communities in the state may be covered.
3. Organizing state mental hospitals so that the acutely ill and convalescent patients are given intensive and regular psychotherapy, while the chronic and dilapidated patients are segregated in wards in which they receive nursing, social, and medical care.

The American Psychiatric Association has prepared new standards for mental hospitals and clinics. The secretary of the association states that governors of 95 per cent of the states have reacted favorably to the high A.P.A. standards suggested.

It is hoped that a rating system for mental hospitals will be put into effect within the next several years, probably under the auspices of the Psychiatric Foundation.

These trends indicate that attempts are being made by psychiatric leaders to improve state mental-hospital conditions.

The National Committee for Mental Hygiene, working in coöperation with the American Psychiatric Association, must stimulate much greater interest in industrial psychiatry, to the end that psychiatrists will be used more and more at policy-making levels by our more important industrial corporations. It is interesting to note that the No. 2 psychiatrist of the British Army has become a high official of one of the largest corporations in the British Empire, with full responsibility in formulating all personnel policies. The chief psychiatrist of the Canadian Army is devoting a large portion of his time to advising industrial corporations regarding their personnel problems.

We need more psychiatric leadership at policy-making levels in the government, so that the perplexing problems connected with industrial strife, the distribution of relief funds, housing, welfare, education, and health may be given proper consideration.

It is gratifying to note that the decided ability of Major General Brock Chisholm has been recognized in his appointment as Executive Secretary of the Interim Commission of the World Health Organization. We can be sure that psychiatric and mental-hygiene consideration will be given to all health problems that come before the United Nations.

Human-Relation Classes in Schools. — The Delaware State Society for Mental Hygiene, with the coöperation of the state department of education and the local boards of education, has established a program of human-relations classes in Delaware schools. These classes are given weekly during English, social studies, or home-room periods to seventh-grade and eighth-grade pupils. The teachers in the demonstration school put on the lessons prepared by the Delaware State Society for Mental Hygiene. After these teachers have been observed using a lesson four times, lessons are reëdited and then distributed to coöperating teachers in twenty-seven schools in Delaware and to collaborating teachers in many other states. My assistant and I spend a considerable portion of our time preparing lesson plans and observing the teachers throughout the state of Delaware giving these lessons.

These human-relations classes attempt to give normal seventh-grade and eighth-grade students a better understanding and appreciation of their emotional strengths and weaknesses. Many leading educators and psychiatrists who have observed the classes believe that these lessons will help students become more emotionally mature during their school career.

Special stories or playlets involving emotional problems are given at the first part of each class. The children are encouraged to discuss freely the problems presented in these stories, to appraise the solutions offered, to speculate on the motivations lying back of the behavior, and to indicate, from their own personal experiences, situations parallel to those in the stories. In this retelling of emotional experiences, often bringing out into the open problems they have never discussed

before, a better understanding of their actions generally results.

Any who are interested are cordially invited to Delaware to see the classes in operation. If this is impossible, we would be glad to have you write us asking for specific information and lesson plans.

Out-patient Clinics. — Psychologists who were formerly very much interested in clinic work are being given better opportunities in industrial personnel work. Psychiatric social workers prefer the easier hours of privately supported social agencies. Psychiatrists are going to those places where they may receive more training and, incidentally, have an opportunity of eventually entering private practice. During the war years, in most states out-patient clinics' activities were curtailed, because of decided shortages in personnel. In Delaware we now have only one traveling-clinic team. We expect to secure personnel for at least one more clinic team before spring.

Within the next few years every state mental-hospital system must render understanding and efficient out-patient-clinic service to communities throughout the state. These clinics must work closely with juvenile courts, social-work agencies, and schools. Waiting for the patient to break down and be committed to a state hospital should be as unusual as the horse and buggy on our state highways.

Unquestionably, the National Mental Health Act, if and when financed, will help solve many problems confronting those of us who are working in mental hospitals, mental-hygiene clinics, and other phases of the mental-hygiene field. The act will be especially helpful in improving training facilities for professional personnel, stimulating research into the cause and prevention of mental disabilities, and increasing the number of alert young men and women entering the mental-hygiene field.

The Delaware State Society for Mental-Hygiene. — The officers of the Delaware Society, leaders in business, community, and social life, are all under thirty-five years of age. Our annual budget of $23,000, which is over 9c. per capita for the state, comes largely from the United Fund of Wilmington.

The most successful national health and welfare organizations receive for their national work a percentage of the funds raised by their local and state chapters. The National Tuberculosis Association receives from its local groups 5 per cent of their income or over $600,000 each year. The Delaware Society, which states on its letterhead that it is the Delaware Branch of The National Committee for Mental Hygiene, pays to The National Committee for Mental Hygiene 10 per cent of its income. If other state mental-hygiene societies would follow this example, it would be possible adequately to finance the National Committee, so that it could devote its entire energies to giving leadership in our fight for improved mental health.

QUALIFICATIONS AND TRAINING OF GROUP THERAPISTS*

S. R. SLAVSON

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IN 1944 the Executive Committee of the American Group Therapy Association took under consideration the need for training practitioners in group therapy. Members of the committee felt that, while interest in group therapy had greatly increased and a number of agencies and clinics had introduced group therapy as a part of their treatment facilities, not enough qualified persons were available to carry out these programs. The association, therefore, undertook to sponsor a training institute for a small number of experienced psychiatrists, psychotherapists, and case-workers. Representatives of the association and of agencies in a number of cities met and formulated plans for such an institute.

The original intention was to have psychiatric clinics and social-work agencies release their workers for two days a week to receive this type of training. Students were to be enlisted from New York and nearby cities. Agencies in Boston, Washington, Philadelphia, and in Connecticut and New Jersey towns agreed to send members of their staffs. It was planned to have these students stay in New York one or two nights a week, so as to spend approximately two days in training and study.

Because of war conditions, this plan proved impracticable, and the original plan was modified. A seminar in group therapy for one morning a week was offered instead, and the student body was limited to members of agencies and clinics in metropolitan New York and cities within commuting distances. Only psychiatrists and highly experienced case-workers on a supervisory level were accepted for training.

The American Goup Therapy Association took the stand that the curtailed program might have the effect of setting a

* Presented at the Fourth Annual Conference of the American Group Therapy Association, New York City, January 10-11, 1947.

standard for training, and decided to withdraw from the project. A committee, consisting of Miss Jessie Edna Crampton, of the Brooklyn Child Guidance Center, Miss Anna Kempshall, of the Community Service Society of New York, and Mr. Herschel Alt, of the Jewish Board of Guardians, undertook to sponsor the institute. Seven agencies and clinics were involved.

In all but a few instances, the tuition was paid by the agencies, and most of the case-workers and psychiatrists were released from their duties to take this training. The institute had seventeen students, of whom three were psychiatrists, four, group therapists, and nine, case-workers; one was a psychologist. The sessions were of three-and-a-half-hours duration, with a twenty-minute recess. Thirty sessions were held.

The seminars consisted almost entirely of reading of group records and of case discussions. Records of activity groups, play groups, and interview groups with adolescents and parents of children under treatment were read and analyzed. Considerable theory in psychodynamics, psychotherapy, and general psychology grew out of the discussions, but emphasis was given to techniques and procedures in the practice of group therapy itself.

One of the indications of the value of the institute lies in the fact that all but one of the students continued their studies for a second year through the actual practice of group therapy in their own agencies and clinics. The instructor supervises some of these projects in Connecticut, New Jersey, and New York City. Through the courtesy of the Jewish Board of Guardians, some of last year's participants are continuing in a seminar on activity group therapy at that agency. We also have among the participants several from European countries who are here to learn case-work, psychiatry, and psychotherapy.

It may be of value to record some impressions of this first experience in the training of group therapists.

One is impressed with the fact that only persons with a sound understanding of psychopathology and experience in psychotherapy should undertake the practice of group therapy. This is as true of activity group therapy as it is of the various types of interview, play, and didactic group therapy.

No one who has not had a thorough and prolonged experience in general psychotherapy ought to attempt to do group therapy in any of its forms. Dealing with groups is vastly more complicated than dealing with individuals. In the treatment of an individual, the therapist is to a considerable extent in control of the therapeutic situation. According to his understanding of the needs, at a given time, he may or may not encourage or stimulate the patient's production; he can direct the interview by means of a leading question or a remark; he can go passive and uncommunicative, or actively give interpretation

In groups, this autonomy, and in some respects also power, of the therapist, is either greatly diminished or is denied him. The catalytic effect of the group members upon one another, whether in conversation or activity, is such that the situation is taken out of the therapist's hands. In individual treatment, the therapist has to adapt himself to the emotional state of one patient and to follow the trend the latter pursues. In a group, the therapist must adapt himself to numerous situations and a network of interpersonal tensions that are not present in individual therapy. This is as true of interview group therapy as it is of activity groups. It is for this reason, among many others, that only highly skilled and self-confident therapists can function well in a group-treatment situation. Perhaps Dr. S. H. Foulkes, writing in the London *Lancet*, describes this situation precisely when he says that group therapy "is an instrument so delicate and yet so powerful, that its skilled handling demands more from the therapist than the most difficult individual analysis."[1] Dr. Foulkes' conclusion confirms our own observations.

Another deduction one can make from our training experience is that group therapy is not a specialty apart and separate from the total practice of psychotherapy. It belongs with general psychotherapy. A group therapist must not only have the knowledge that an individual therapist has; he must also know and understand the background of the patient, his intrapsychic problems and treatment needs, as does the individual therapist. One cannot master the group techniques

[1] "Group Analysis in a Military Neurosis Centre," by S. H. Foulkes. *Lancet* (London), Vol. 250, pp. 303-6, March, 1946.

apart from these general understandings that are essential to all psychotherapy.

We have also observed that the skills of psychotherapy are not always a part of the case-workers' and psychiatrists' equipment. There is a considerable schism between descriptive and diagnostic psychiatry and its dynamic, therapeutic counterpart. One deals with the results and symptoms of total personality breakdowns; the other with chronic or acute malintegration of the human organism. In the latter, treatment aims either to establish *ab novo,* or to reëstablish, feelings and attitudes appropriate to social adaptation and inner harmony. We have found that frequently knowledge of psychodynamics and even of psychopathology does not guarantee skill in psychotherapy, and that one cannot undertake the practice of group therapy on that basis alone.

The worker with activity groups, for example, in which no discussions are held, needs to understand the latent meaning of behavior as well as the statements patients make. A boy who asks the group therapist for the key to the door, unlocks it, and then unlocks the materials closet is evidently seeking to displace the therapist in the group. While at first glance it may seem that he wishes to be helpful, actually this is not the case. Through this act the boy is manifesting a desire to displace the father in the family. Where the father is a weak person or is absent from the home, the boy strives to become worthy of the mother and assume the place of her husband. He, therefore, plays the rôle of an adult, which he also attempts to do in the group.

Another common example is the child who runs in breathlessly to the group session. This is usually an expression of sibling rivalry. The child rushes to the group in order to be the first one there. Unless there is an element of neurotic anxiety that permeates all his behavior, this is in most cases an expression of sibling rivalry.

The therapist has to perceive the hidden meanings of sometimes rather simple statements that may seem to have no special significance. The following situation in a group is typical:

The therapist is cutting cake, and the children around the refreshment table discuss food. They make plans for the next

meeting. The children express their preferences. Some vote for chocolate cake, some for pineapple, others for apple. One of them says: "I like any kind of cake — chocolate, pineapple, most any kind." In saying this the child does not actually express his preference. He rather tells the therapist that he is pleased with whatever the therapist does for him. It is an act of submission, and we may assume that this child has been required to act submissively to one or both parents in the family.

In interview groups the patients' statements have as much and even more hidden meaning. The therapist must deal with them in a manner that has therapeutic validity. Questioning the patient may be indicated, to bring out the meanings that he attempts to hide; the therapist may interpret, in order to convey understanding of the problem and evoke insight, or he may overlook it, so as not to encourage the patient to go beyond his or the group's readiness for insight.

Understanding of the patient's behavior and statements are, however, in themselves not sufficient for therapy. In all therapy, and especially in group therapy, the skill lies in dealing with them. Where the child seeks to displace the worker, the therapist must be very careful not to play into the boy's pattern. In the case cited, the therapist did not perceive the intention of the child and asked him to go out to buy the food for the group. In so doing, he reënforced, and gave consent to the boy's strivings to displace him and live out the fantasy of being better than the adult (father). What the boy needed, rather, was to accept his own age and his childhood. In this he would be helped through identification with the other members of the group by working with and playing with them, by becoming a part of a group of children, and through finding sublimations of this primary drive. When the therapist reenforces and endorses these strivings, he is retarding the child's maturing process.

In the case of the submissive child just described, it is quite evident that the therapist and the group should help him build up his ego strengths and autonomy through support by the therapist, through assurance of his status in the group, and through successful achievement. The therapist in this instance lends himself as a focus of attention, but through subtle strat-

agies gradually removes himself from the center of that attention. In dealing with defective ego development, the therapist serves as a temporary prop only.

In the case of the boy with intense rivalry, the activity-group therapist does not attempt to deal with the problem in any specific way beyond his fundamental positive rôle of acceptance and permissiveness. This problem the child has to work out by himself with the other children as sibling substitutes in relation to the therapist.

In interview groups, on the other hand, attitudes are employed for exploration, direct interpretation, and insight-giving. The subtleties for dealing with the myriad situations that arise in groups can be acquired only through actual experience with groups and supervisory interpretations, not through classroom studies.

Because of the need for knowledge of general psychotherapy as a background for the practice of group therapy, the founding of a graduate school for psychotherapy was suggested. The present writer prepared a memorandum, including a tentative curriculum, on such a school.

Because it is becoming more and more evident that the need for psychotherapy cannot be met by the small number of medically trained psychiatrists, and that this lack is not likely to be met in the foreseeable future, such a school is badly needed. Despite the increase in the number of persons who are suffering from emotional disturbances, facilities for treatment are sadly lacking. The prohibitive cost of private treatment makes it available to comparatively few, and social-work agencies and out-patient hospital clinics are in most instances not equipped to offer adequate psychotherapeutic services.

It is becoming increasingly evident that medical training as such is not essential for the practice of psychotherapy, providing the therapist does not attempt to deal with psychotic and with organic patients. The lay therapist cannot be too cautious in this respect. He must be able to recognize patients who do not fall within his purview and be bound, both legally and in honor, not to undertake to give treatment beyond his limited competence. He should in all instances have a prospective patient examined by a general physician, a neurologist, and a psychiatrist.

The aim of such a graduate school for psychotherapy would be to train qualified persons, both medical and non-medical, in the science and art of individual and group psychotherapy, preparing them for licensed private practice and, especially, for positions in clinics and institutions.

To qualify practitioners in psychotherapy, the following three-part curriculum, is suggested:

I. Orientative studies on an elementary level in embryology, anatomy, physiology, neurology, endocrinology, child development, social psychology, sociology, and abnormal psychology.

II. Professional courses, including depth psychology, basic psychiatry, diagnosis, individual psychotherapy, and group psychotherapy.

III. Field work and practice in a clinical setting under competent training supervisors, preferably psychiatrists.

The aim of the orientative courses would be to give students a basic understanding of the total personality as a biological and social organism. The professional courses and field work, on the other hand, would need to be considerably more intensive and of at least two-years duration.

It is suggested that the school be open to university or college graduates with degrees in psychology, to students with pre-medical training, and to graduate physicians.

Only a degree of Master of Psychotherapy should be awarded to students who meet all the requirements of the school, no doctorates being granted. The faculty would include medical and non-medical psychotherapists of outstanding achievement and prolonged actual experience in psychotherapy, in the training of psychotherapists, or in both.

The intention of the orientative courses would not be to train specialists in the fields in question. It is recognized, however, that if therapists are to treat the total personality of the patient as a unitary bio-psycho-social phenomenon, instead of treating his symptoms as isolated entities, they must understand the various elements that go into the making of personality and their dynamic interrelationship. They must know the structure of the human organism, its dynamics, and the integrative process in the body-mind organization of man. Despite his major preoccupation with man's psyche, Freud

did not fail to note this unitary nature. He affirmed that stimuli travel from the soma to the psyche, and from the psyche to the soma. This fact is the foundation of psychosomatic medicine and is the origin of somato-psychologic phenomena.

Adequate place must be given to the study of the psychological causes of somatic disturbances and the somatic causes of psychologic difficulties. It seems quite clear that human maladjustments are not in all cases psychogenic, although an overwhelming majority may be so. The fact that in the past psychogenic factors were grossly overlooked has caused a swing to the other extreme, resulting in overstress upon them. Patients who come for psychotherapy often present mild or even gross organic deficiencies that are either the root of the maladjustment or important contributing factors. Despite the predominance of psychogenic causes, organic factors also must be taken into consideration in a total-treatment plan.

Our experience has also led us to the conclusion that persons who deal with pathology should have some knowledge and appreciation of the normal needs of normal people, and not limit their studies to pathological conditions only. Children present behavior problems when they have suffered consistent and prolonged frustrations in the area of neuromuscular activity and creative self-expression. The latter serves as a sublimative activity, yields ego gratifications, and meets the requirements of one's basic dynamism. Pathogenic relations, authoritarian, repressive, rejecting, and hostile attitudes of parents and teachers, are quite clear to us, but not so clear is the fact that the very learning process and the frustration of motility and active dynamism are equally damaging to the physical and mental health of the child.

Persons who practice the healing arts are aware of the existence of basic needs rooted in the biological nature of man and the requirements of his vasomotor activity expressed in rhythmic and dynamic forms. The child passes through many phases in his development, each having its own place in the formation of the final product, the adult. During his orderly growth, the child passes through the cycles of the manipulative-exploratory, the practical-inventive, the intellectual-epistomonic, and the social-participatory phases. All of these leave their imprint upon him. Inadequate fruition

of any of these destroys the harmony of the body-mind and the integrative processes of the personality. Mental health can be achieved only when full growth in each phase is fully achieved so that the subsequent level can be fully utilized.

To understand normal development dynamically, one needs to recognize the stages of nurture, discipline, and education in the development of the child. Personality problems and mental unhealth are frequently caused by the inappropriate treatment of the young child during these three phases in his development. The earliest needs of the child are those of nurture: he needs to be protected unconditionally, his wants and needs immediately satisfied, and his survival securities assured. The stage of discipline in elementary function, such as voiding and eating, are the next phase. This discipline has to give way to education, which in its ideal sense means the bringing forth of the potentialities of the human personality.

The involvement of the neuromuscular, the vasomotor, and the endocrine-emotional systems as a total and unitary phenemenon in growth and education is too evident to require elaboration, and one who is not aware of these dynamic processes and their place in total health overlooks many therapeutic opportunities. One may misjudge emotional reactions unless one understands the total personality.

This perspective of child development gives one a scientific base for psychotherapy. It also yields a fuller appreciation of the complex phenomenon known as man. We must also take cognizance of the individual differences of people. While men are alike in gross structure, they are vastly different in many and important respects. Tempermental dispositions, congenital and hereditary variations are too great among individuals to warrant our demanding from them identical, or even similar, reactions, or expecting of them the same capacity to bear stress and tolerate frustration. Thus what is a "normal" situation for one individual may be a problem to another.

It is upon these broader insights, perceptions, and appreciation that good psychotherapy should be based. Dealing with people is predominantly an art and much less so a science. But the art element is rooted in science. It is in the science of man that the art of dealing with human beings is refined.

Science also serves as a check upon the effectiveness with which, and the direction in which, the art is practiced.

Very little need be said about the professional courses and the field-practice parts of the program. These should all be practical and based upon actual experience. The seminar courses for the group therapist should be based upon the records of practice. Sound therapy in this field must grow out of experience rather than the other way around. Both epistomologically and behavioristically every teacher knows that the inductive method in education is far more effective than the deductive.

A committee is at present engaged in formulating plans for making possible training in group therapy along the lines indicated. A group of representative persons from a number of cities are interested in this plan. An analysis of the needs made by them presents two aspects. One is the immediate need for training persons who would be qualified to introduce and direct group therapy in agencies and clinics. The other is a long-term plan for training postgraduate students.

As an immediate step, it seems to be most appropriate to offer training to persons who have qualifications for, and have had prolonged experience in, individual psychotherapy, such as psychiatrists, case-workers, and therapeutic psychologists. Because of the advanced standing and experience of the students, the curriculum for this group would be focused around group therapy and would consist of (1) a seminar in dynamic psychiatry; (2) seminars in group therapy; (3) supervision of the students in groups; (4) intensive supervision on an individual basis; (5) field work in hospitals and agencies; (6) a psychiatric consultation service for students; (7) a review of the history and current practices in group psychotherapy; (8) analysis of the literature in the field; and (9) administration, recording, and the integration of group therapy into agency programs.

We have been receiving numerous inquiries, from sources beyond our country's boundaries as well as from many cities in the United States, about the establishment of group-therapy projects. South America, South Africa, and especially European nations have evinced a very strong interest in group

therapy. We have entertained representatives of many of these countries in our office. Some were able to observe groups in action through a specially constructed screen; all read our literature and records. We have supplied them all with materials, copies of records, and other information. In several countries projects have already been set up; in others group-therapy projects are planned. We are coöperating in planning therapy groups for the blind in New York City and have been consulted by many psychiatrists and social-work agencies from many parts of the United States on matters relative to group therapy. Thus there is little doubt of the need of trained group therapists. The problem that we now face is how to make such training available.

GROUP-TREATMENT POTENTIALITIES IN AN AUTHORITATIVE SETTING*

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ONE of the most acute feelings of individuals committed to an institution is that of loss of freedom. They are required to eat, work, and play under a plan of group supervision. In this paper, I shall attempt to analyze some of the psychological factors that develop in the group living of an institution, drawing parallels between such institutional life and life in the army. Discipline and authority are the overtones of these institutional settings, and I will attempt to show how this authority can be used constructively to aid the socializing process in those who have been committed, so that they may return to community life. I shall discuss types of group and their treatment potentialities, leadership, in-service training, and the use of individual treatment as it may be coördinated with group treatment, as well as the general responsibilities of administrative and professional personnel.

Our specific concern here is how the functional and psychological structure of group treatment in an army setting can be applied to an institution for delinquents. In the army the institutional setting is determined by administrative and medical authority, and may be either a prison or a hospital. The typical reaction of the psychoneurotic patient who, by army regulation and authority, is sent to a convalescent hospital for treatment is the desire to "get out," with the concomitant realization that this decision will depend upon the authorities of the institution. In many respects, the reaction of the delinquent committed to an insitution for treatment is similar,

* Presented at the National Conference for Juvenile Agencies, Detroit, October 5, 1946.

except for the few for whom the institution represents a complete protection and a welcome relief from individual responsibility.

Medical authority in the army commits the soldier whose difficulties in line of duty have precipitated a new or an old neurotic pattern to a course of treatment that will return him either to duty or to civilian life in better condition than when he was admitted to the hospital. In committing the delinquent, the court attempts in a similar way to assure the individual's recovery through the use of the treatment facilities of the institution. In both situations, the individual feels the strain of having to adjust to a controlled environment that is not of his choice. He experiences the need to fight these new and repressive measures that stem from group life under authoritative regulation.

Early in 1943, neuropsychiatric casualties in the army began returning for hospitalization and treatment. The purpose of the army installation with which I was connected was to treat those who could be expected either to return to duty or to be discharged within a reasonable length of time. Treatment on a group basis was begun with a company divided into several platoons. We had to plan almost immediately on this group treatment because the number of patients far exceeded the number that could be placed under individual supervision, and group organization seemed to be the only way in which we could provide adequate treatment facilities. We realized also that treatment potentialities would be utilized to the maximum when we coördinated our individual-treatment plan with the group organization we had established. Along with the company set-up, group activities were started in automobile mechanics, journalism, administrative and clerical work, and electrical and repair work, to mention but a few. Our personnel for treatment consisted of psychiatrists, medical officers, psychiatric social workers, psychologists, company commanders, and all the enlisted personnel required to operate its functions. A problem we had that I believe is also one in civilian institutions was that of insufficient staff to provide an effective individual-treatment program.

One of the first tasks we had was that of diagnostic screening, to determine who would be eligible for treatment on this

basis. We did this through evaluation of the degree of the soldier's illness and of his ability to relate to the facilities of the installation. Soldiers who appeared too ill were sent to closed-ward hospitals.

From the first day of the patient's arrival at the hospital, he was helped to understand, through personal interview and group orientation, that the army had invested us with a specific responsibility — that of enabling the patient to meet army standards of adjustment before he left the convalescent facility. In discussion with the social worker, the soldier was oriented to the kind of group living he would experience. He was told about the many groups of which he would become a part, and was given to understand that his reactions in these groups would be one of the tests by which his adjustment would be followed and evaluated. In this way individual treatment, which was given to those soldiers whose problems indicated the need, was joined to the group activities. This gave the patient some understanding of the meaning of his commitment to the institution.

In the patient's orientation, this joining of individual and group experience diffused hostile feelings against any one superior upon whom he might project the blame for his illness and his behavior patterns. The patient was also told that there were some activities about which he would have little choice—such as assignment to a company, a platoon, physical-education classes, and others — but that there were activities in which his needs and interest would be the first basis for determining his placement. He was told that he would be assigned to a psychiatrist or a case-worker for individual help. For he had been, by army regulation, diagnosed as ill.

I want to make clear here that, both in the beginning and as treatment progressed, the emphasis was not solely upon the symptoms and causes of the patient's behavior. The symptoms were also discussed in relation to the effect they would have on the patient's adjustment to his groups. We considered what problems a platoon assignment would create, and what vocational or occupational interests might determine the patient's assignment to an activity group.

For example, a soldier who was an automobile mechanic in civilian life and a tank repairman in combat saw two of his

buddies blown to bits at the stalled tank on which he was about to make repairs. In his assignment it was obvious that he would want least of all to look at another piece of machinery, the mere sight of which might precipitate a violent hysterical outburst. In another case, a soldier who was physically capable of keeping up with the first platoon could not bear the thought that the medical officer believed him capable of maximum physical performance. In combat he had had a severe anxiety attack when a little more stamina would have helped him to rescue a drowning friend. For us to have placed him in the first platoon, in which all individuals were physically fit, would only have intensified his guilt feelings. He was placed in the third platoon, designed to accommodate men with symptoms that limited their physical activities, and slowly regained his self-confidence through testing himself out in a group of limited activities. When he began to exercise his full physical ability without feeling overcome by guilt, he was transferred to the first platoon.

This illustrates not only the use of individual treatment, but also the coördination between individual treatment and platoon group leadership, the keynote of which is the constructive use the group leader makes of the knowledge made available by the social worker. All our groups were formed and guided by one main consideration: What use could the patients make of a given group to develop their capacity to adjust in a realistic setting, either in future duty or in civilian life?

Before going into an analysis of the groups, I should like to discuss the personnel required to lead them. A person in a position of leadership in a group must clearly understand that his authority is primarily one of helpfulness, not an authority for the purpose of regimentation and repression. This negative orientation can be very destructive in its effect upon groups and individuals. The responsibility of a leader is not merely to get the patient to work or to keep him from being alone, with the possibility that he may get into trouble, although this is occasionally the orientation that leaders in institutions have. In institutions lay persons are often placed in positions of group leadership, and this non-traditional concept of authority may not always be readily acceptable to

them. If the lay person can accept his primary rôle as one of helpfulness, then his leadership can reach its maximum effectiveness.

It was neither possible nor necessary to have all groups led by professionally trained staff. From the company commander through his subordinate enlisted personnel, it was of importance to have a clear understanding of our treatment objective. We selected our so-called lay personnel because of their interest, their objective attitudes, their intelligence, their sensitive use of authority, and their acceptance of the hospital's primary medical purpose. They were trained in groups, with frequent opportunity for individual discussion with psychiatrists and social workers. They submitted weekly progress reports, or brief reports on the adjustment of patients after each group, and these were available to the psychiatrist or the social worker. The responsibility for a report stimulated the group leaders to evaluate the patient and at the same time contributed to their awareness of the individuals within the group. Thus it was possible to staff all group activities with reasonably effective personnel and to stimulate their development on the job. Many grew to a real understanding of their work and felt that they were a part of this large treatment team. Their responsibility was never underestimated; this, we found, was an important key to successful group planning within an institution.

A continuous in-service training program can meet the need to make constructive use of carefully selected personnel. This kind of program could be a part of many institutions. I have discussed the value and method of using lay personnel because the usefulness of professional workers can so easily be lost when they are given too many activities to handle.

The selection of patients for discussion groups was determined by the symptom picture instead of by the clinical diagnosis. As far as possible, the groups were homogeneous and divided into three main types: (1) those who suffered from worry and different forms of anxiety, (2) those who had physical symptoms without an organic basis, and (3) those whose problem was that they were continuously negative and hostile. In addition, some of these groups were further divided on the basis of overseas combat service, and service within

the continental limits of the United States. The reasons for this are obvious in view of the identifications established between the members of these two latter groups.

The purpose of discussion groups was to promote an understanding in the patient of the development of his symptoms. Use was made of visual aids. Each individual was given an opportunity to discuss the development of his symptoms and to compare his experiences with those of others. Each discussion group was led by a psychiatrist or a social worker whose responsibility it was to direct and make use of the patient's feelings.

Many patients were in a negative cycle of behavior, each problem in their adjustment being justification for the one that followed. Little progress could be made through a theoretical discussion of such behavior as long as the patient used the leader and all other persons in authority in the installation to justify his inability to get along. The group leader would help the patient to realize how much energy he was expending in perpetuating his problems and what effect this would have on his final disposition. As the cycle of negative behavior became less important for the patient, he would begin to consider how he could constructively use the group program toward the goal in which he himself was most interested.

Recreational and social activities presented excellent areas in which the individual could test himself; such material was used in the discussion groups. Excessive preoccupation with illness and withdrawal were common and highly disturbing symptoms for those who on home visits felt that they could not find their way to a familiar pattern of adjustment. A Monday morning session often started with individuals in the group asking questions about their experiences. There was a striking similarity in the incidents that they all encountered at home with relatives who could not understand their symptoms, friends who prodded them about their army experience, inability to sit through a movie, and so on. They all experienced the same problems and sharing these in a group discussion gave them a considerable feeling of personal reassurance. If delinquents were permitted home visits, it would seem that group discussion with them could provide a great

deal of material for evaluating their reactions to their friends, their gangs, and their feelings about being different now that they were in an institution. Such experiences would bring their problems into realistic proportions.

Effective as this type of group treatment was, it would not have been complete without coördination with parallel individual interviews in which the patient could take up the many personal implications that the group process had set in motion.

The activity groups fell into two main types: a company, with its three-platoon set-up, and the various so-called classes previously mentioned. The company, functioning as a treatment group, had as one of its responsibilities that of helping the soldier adjust to the basic unit of all army life, the company. The platoons were led by competent enlisted men and also by some selected patients. The use of patients as group leaders had many positive effects, both for the patient leaders and for the group. In some group members this relationship to patient leaders developed a healthy competition, and gave the patient leaders an opportunity to test out their self-confidence. For one of the commanding officers, it offered a degree of security in his potential command function (a responsibility around which his previous breakdown had been precipitated), so that he was later able to become an administrative officer of a large hospital unit in an overseas theater of operations.

The adjustment of each individual within a platoon was periodically reported to the social worker. Positive handling in the groups' everyday army routine was assured by conferences with the commanding officers and the platoon sergeants. Activity groups were organized on the basis of the patient's own interest. Assignment was determined by interest and ability to participate rather than upon the diagnosis.

A serious handicap faced by many patients was the loss of self-confidence and security. Some patients did not join any group, but had special or unusual interests and were permitted to work independently, except for the required details in which all were expected to participate. These groups did not have an educational or teaching purpose, but rather provided the patient with an interest through which he experienced some positive self-sustaining activity.

The patients were encouraged to participate at their own

pace. The activity groups were run quite informally, beginning or ending with discussions of the session's work. Individual reaction was encouraged and the intra-group effect of a patient's progress — or of his retrogression — became a factor against which others could weigh their own adjustment.

Every patient was helped in his selection of a group. One might want to try his hand again at a job to see whether he could perform it in duty status. Another, whose return to duty seemed unlikely, might choose a group activity on the basis of future job and occupational interests. In this sense these projects served a secondary purpose of group vocational guidance. At times it was found desirable to change the group placement of the patient or to withdraw him from the group entirely.

For the ultimate disposition of the patient, the groups provided a reality test of adjustment upon which an evaluation of the individual's progress could be made. In the army we called this a "trial of duty." In this connection a rather frequent phenomenon occurred. For example, some patients who complained bitterly to the social worker and walked with a heavy limp were seen running the bases on the ball field with a great deal of energy. Such a healthy reaction in one phase of the patient's activities was always made a part of the individual-treatment interview.

I would venture to say that this group program has certain elements that might be applied in helping the delinquent committed to an institution. Delinquency, simply defined, except where the psychopath is concerned, is the expression of an inner conflict that precipitates behavior in direct conflict with what is socially acceptable. This type of behavior creates problems for the delinquent, even though he has come to depend upon this pattern to gain satisfaction for his inner neurotic needs. Readjustment will occur when he has found constructive substitutions in work, play, and social relationships, along with an understanding of his behavior. The community to which he looks to return is the ultimate arena in which his change will be important. Therefore, activity groups that can be provided for the delinquent within an institution may be used to stimulate self-satisfying and socially acceptable behavior. The use of group discussion and group activi-

ties can be made an important tool for enabling the delinquent to test out the understanding and insight gained through individual treatment.

Of the individuals helped, those with a diagnosis of combat anxiety showed a high degree of recovery. At the same time, patients suffering from a wide variety of symptoms reflecting physical illness offered a good prognosis. The psychopaths, of whom we had relatively few in our installation, presented considerable difficulty and often desired a return to active duty. The majority were discharged, in keeping with pertinent army directives. The hostile, asocial person whose negative effect upon group morale is well known should be segregated so that the maximum use of the treatment for others is not destroyed.

Behavior that resulted in disciplinary problems was viewed from the standpoint of medical responsibility. Although normal army procedure and punishment were used, this was not done without consulting the psychiatrist or the case-worker. Ordinarily any staff member had the authority to use or to recommend disciplinary action. He was not deprived of this authority, although his decisions were subject to review. This was to maintain a check on the subjectivity of the lay person. We know that disciplinary problems are created by poor handling, but patients were often inclined to seek refuge behind their medical problems or the social worker. The latter was careful not to line up with the patient against the group leader. The breaking of rules was usually the fault of the patient and was used positively to point out the problems of adjustment he was still encountering.

Patients who expressed confidence that, once permitted to return home, they would have no further problems, were brought back to the fact that the disposition board made this decision on the basis of their adjustment in the various group situations, which thus made for a realistic appraisal of the facts. In the group when one person might bring out his feeling that he was sufficiently well to leave the installation, other group members who knew him well and did not think he was ready frequently gave him a challenge to work against. At the same time those who might not agree with another patient's opinion as to his progress were themselves given

an opportunity by the leader to discuss their own. The leadership and sensitivity required here obviously demanded skilled supervision by a professional person.

It was important for the patient to have as many positive experiences as possible. Group leaders picked up even the slightest degree of progress, such as increased activity and participation, work on a project however small, heightened sociability, and decreasing tension. Whenever the group leader could see some small evidence of progress, this was used in the group and simultaneously in the individual treatment situation. The activity groups were flexible and it was possible for a patient to change from one group to another, provided the change was constructive. However, an effort was made to keep discussion groups intact by not introducing new patients because of the group developmental process. In the activity groups there was always a sufficient wide range of participation to make it possible for a newcomer to fit in.

I have emphasized the need for coördination. It is quite possible for a group to have excellent facilities and leadership and yet not to function on an effective treatment basis. All groups within a given institutional setting must be geared to the primary goals of the institution. They will partake of the treatment function only to the extent that it is coördinated with the effect of all activities upon the individual. This requires centralized medical and administrative supervision delegated from the highest authority within the institution on down to every person in charge of a group or detail. This is not a one-way street, however, and provision must be made for a return flow of information, problems, and grievances.

This type of two-way supervisory and group-leadership structure makes it possible not to pass up problems or to give any one group leader total responsibility for his own group. The formation of group islands within a multiple group setting has in it the danger of isolation from the central theme and purpose of the institution. This affects both leader and individual and cannot be counteracted through more leadership or more discipline within any given group. Since most institutional work, by the very nature of the problems of its residents, involves sick people, the responsibility of all per-

sonnel should be derived from a medical-psychiatric authority. It is not necessary for a conflict to exist between medical and administrative responsibility. Wherever the two are separate or at odds, there will be problems of staff morale and patient adjustment. No matter how hard a professional or lay person may work on his own island, he will never succeed in his mission until he establishes a link with others. There is always a certain amount of healthy competition between groups, but when that competition engulfs the leaders of groups, the patient as our central concern will again be lost. The group leader who is chiefly concerned with the good behavior of his group as against the behavior of another leader's group will not be able to avoid the pitfalls of petty jealousy which will sooner or later destroy his work as well as his status.

Although coördination is the responsibility of each group leader, it cannot be achieved without participation on the part of the institution's administrative staff. Where the administration and the medical staff have established a uniform policy that has become known to all persons in charge of groups, the problem of isolation will be at a minimum. All are aware of the groups and cliques that develop among the staff in an institutional setting. Where this occurs, it is usually because the administrative staff itself is part of a clique. Through a process of identification it can readily be seen what an impetus will be given to the patients for clique formation. This is a well known factor in the disturbing of morale.

Coördination, once started in the form of staff meetings, in-service training, talks on the institution's purpose, and through other means, must be a continuous process. Any let-up in such a program will weaken the position of the administration. Persons in administrative responsibility within institutions know how quickly one's sensitivity to the real functioning of the institution's life can be lost. An imaginative searching out of staff attitudes is required. This cannot be the sole responsibility of a few persons, but must become the job of every leader, no matter how trivial his function may seem.

In conclusion, I would like to say a few more words about authority. To form a group for the sole purpose of seeing

a well-ordered column march to the dining hall may easily stimulate hostility and poor morale if it is felt by the delinquent as a repressive measure. Adherence to military systems of regimentation is not conducive to achieving the treatment goals of an institution. The individual is not being prepared to fit into a regimented society. Those who cannot get to the dining hall on their own have a problem in being responsible for themselves. It is this with which they need help. We are trying to help the delinquent to be responsible for himself and to make positive decisions on his own. In the community no one will help him to be on time to a job; if he does not get there himself, he will lose the job. There is sufficient purposeful authority within the necessary group organization of any institution, as there was within the army, to make additional regimentation harmful.

Institutions must always be conscious of the dependency fostered by the mere fact of institutionalization. For this reason all existing groups should be supervised closely and frequent progress reports on the individual should be obtained. When an individual has made a good adjustment to one group, it would be better to let him spend more time in those groups in which his problems are greatest, and thus give him a share in the progressive movement toward ultimate discharge. Through this awareness, the harmful and dependency-producing effect of a too lengthy institutional stay can be minimized.

These statements are the result of over three years' experience in the army within an institutional setting not unlike that of many civilian institutions. Part of what has been said here will sound familiar to you in the problems you are facing daily. There is no single true formula for group treatment. What I have attempted is a description of how we used some of the inherent group-treatment possibilities in an army hospital. Some of this will have to be modified according to individual needs and problems. At the same time I believe that the authoritative atmosphere of an institution, with all of its natural group formations, presents a wealth of opportunity for group treatment.

THE WAR VETERAN IN THE DOMESTIC-RELATIONS COURT

A STUDY OF 200 CASE RECORDS OF THE MUNICIPAL COURT OF PHILADELPHIA

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THE Municipal Court of Philadelphia, through its several divisions (juvenile, misdemeanants, domestic relations, adoption) exercises a broad jurisdiction in matters concerning family welfare. Its domestic-relations division, in particular, disposes of cases of desertion or non-support of wives, children, grandchildren, and indigent parents, and also of cases involving the custody of children. It does not, however, confine its activities to cases of litigation only; it seeks to avoid formal court procedure and formal court disposition, whenever a reconciliation between the parties—in most instances between husband and wife—can be achieved. Toward this end, the probation department of the domestic-relations division arranges interviews and informal conferences with husbands and wives to encourage the adjustment of marital difficulties without court action.

In view of the numerous publications that deal with problems of marital adjustment of the returning serviceman, it was natural that the court's department of research and statistics should wish to investigate the scope and the character of domestic-relations situations brought to the attention of the court in which the husband had served or was still serving in the armed forces of the United States. Consequently, the interviewers of the domestic-relations division were instructed to earmark those cases for special study and to obtain in the course of their interviews the necessary data relating to the military service of the husband.[1]

[1] Credit is due to Mrs. Florence M. Shughrue, supervising interviewer, and her staff of interviewers for their much appreciated help and coöperation; also to Miss Cecilia R. Flick, district supervisor in the probation department of the domestic-relations division, for valuable suggestions.

All new cases were included—*i.e.*, those cases that came to the interviewers' desk as new complaints. Complaints were considered as new even though the domestic-relations division might have had previous dealings with the family that had been terminated either by court decision or by informal closing of the case.

The time covered was from January 1 through October 9, 1945, a period of nine and a third months, the decisive date being the day of the first interview after the complaint was made. Two hundred cases were thus indicated by the interviewers as belonging in this category. They form the objects of this study.

The records of the 200 cases were excerpted in order to gather data on the following items:

1. *Face Sheet Information:* identifying record number; name; date of complaint filed; old or new case; color or race; age of husband, age of wife (as of date of complaint); number of children, if any.
2. *Data Relating to Marriage:* month and year of marriage; war marriage or not; if a war marriage, how long did partners know each other prior to marriage; if a war marriage, did they marry with parental sanction.
3. *Data Relating to Military Service of the Husband:* date of entering service; enlistment or induction; branch of service; length of overseas duty, if any; if so, battle experience, if any; date of discharge; reason for discharge.
4. *Data Relating to Court Action:* source of complaint; immediate reason for domestic friction; if married before husband's enlistment or induction, were there marital difficulties before enlistment or induction; object of complaint; status of case.

The reading and excerpting of records of the first hundred cases was done during the month of August, 1945, and of the second hundred cases in January and February, 1946.

The only available control group was the total of cases of desertion or non-support that were handled by the domestic-relations division of the municipal court during 1945. This control group of 3,600 cases was selected because vital statistics (age of husband and wife, length of married life, number of children, racial composition, and so on) for this group are included in the annual report of the municipal court for 1945.

Therefore, whenever statistical data for the control group were available, the group under study was compared with it. In other instances, however, correlation with other figures

was made—*e.g.*, with general-population or war-department statistics.

Age of Husband and of Wife.—In 197 cases, the age of the husband was known. The lowest was nineteen years (three cases) and the highest 51 years (one case). The ages most frequently represented were twenty-five (20 cases) and twenty-seven (18 cases), closely followed by twenty-three and twenty-four years (17 cases each). The mean age of husbands in the group under study was twenty-seven years, eight months, as compared with the control group, in which it was thirty-two years, two months. In the group under study, 66.5 per cent of the husbands were under thirty years of age while in the control group the percentage was 36.[1]

In all 200 cases, the age of the wife was known. The lowest was sixteen (four cases) and the highest forty-five years (one case). The most frequently represented ages were twenty-three (30 cases) and twenty-six years (17 cases), followed by twenty-one and twenty-four years (16 cases each). The mean age of wives in the group under study was twenty-five years, eight months, as compared with the control group, in which it was thirty-one years, six months. In the group under study, 77.5 per cent of the wives were under thirty years of age, while in the control group the percentage was 52; in the group under study, 17.5 per cent of the wives were under twenty-one years of age as compared to 11 per cent in the control group.[2]

The differences in age distribution between the group under study and the control group are, of course, explained by the selection of the study group, which was composed exclusively of couples with husbands of military age.

The mean age difference between the individual husbands and wives in the group under study was two years, three months, the husband being the senior. This is somewhat less than the mean age difference between husbands and wives in the whole United States, according to the Census figures—namely, three years, the husband being the senior.[3]

[1] See *Annual Report of the Municipal Court of Philadelphia for 1945*, pp. 133–134.

[2] *Ibid.*

[3] See *Marriage and the Family*, by Ray E. Baber (New York: McGraw-Hill, 1939), p. 179. See also *The Family*, by Joseph Kirk Folsom (New York: John Wiley and sons, 1934), p. 8.

Details as to age distribution are presented in Table I.

TABLE I. AGE DISTRIBUTION OF 200 HUSBANDS AND WIVES

Age	*Number of husbands*	*Number of wives*
16	..	4
17	..	2
18	..	8
19	3	10
20	6	11
21	10	16
22	17	9
23	17	30
24	12	16
25	20	8
26	11	17
27	18	10
28	8	7
29	11	7
30	4	8
31	10	6
32	7	4
33	7	3
34	7	6
35	4	2
36	4	2
37	5	4
38	4	3
39	4	..
40	1	2
41	..	2
42	2	..
43	2	1
44	2	1
45	..	1
51	1	..
Not reported	3	..
	200	200

Color or Race.—In 134 cases, husband and wife were white. In 66 cases, or 33 per cent, husband and wife were Negro, as compared with 36 per cent Negroes in the control group.[1]

Length of Married Life.—The date of marriage was known in 199 of the 200 cases; the one remaining case was a common-law marriage.

The length of married life on the date when the complaint was filed was recorded as shown in Table II.

[1] See *Annual Report of Municipal Court of Philadelphia for 1945*, p. 134.

TABLE II. LENGTH OF MARRIED LIFE OF 200 COUPLES

Number of years of marriage	*Number of couples*
Less than one year	11
1 to 2 years	20
2 to 3 years	43
3 to 4 years	25
4 to 5 years	22
5 to 6 years	14
6 to 7 years	13
7 to 8 years	14
8 to 9 years	3
9 to 10 years	8
10 to 15 years	14
15 to 20 years	9
More than 20 years	3
Not reported	1
	200

Sixty-seven and one-half per cent of the couples in the group under study had been married less than six years; in 49 per cent of the control group, the marriage was less than six years old.[1] The largest number of cases in the group under study was in the third year of marriage; this was the second highest category in the control group. But while in the control group this category accounted for 9 per cent of all cases, it was more than twice as high in the group under study, in which 43 couples, or 21.5 per cent, had been married between two and three years at the time of filing of the complaint. This group of 43 couples had been married some time between January 1, 1942, and October 9, 1943; it constitutes to a large extent the group of so-called "war marriages," which are discussed below.

Obviously from the selection of the group under study—that is, couples with husbands of military age—the number of couples who had been married less than six years would be considerably higher in the study group than in the control group.

Time of Marriage in Relation to Husband's Serving in the Armed Forces.—In 145 cases, or 72.5 per cent, the marriage had taken place prior to the husband's induction or enlistment. In 33 cases the marriage was performed during the

[1] See *Annual Report of the Municipal Court of Philadelphia for 1945*, p. 134.

time the husband served in the armed forces; in 16 cases, after the husband's discharge from military service. In six cases the time of marriage in relation to the husband's military service was not determined.

War Marriages.—The category of "war marriages" cannot easily be defined. In a strict sense of the word, only those marriages that were performed while the husband served in the armed forces and those marriages that were entered into immediately preceding the husband's induction or enlistment may be thus classified. There were 58 such marriages in the group under study.

If a broader interpretation is given to the term, all marriages that followed Pearl Harbor may be counted. Eighty-nine couples in the group under study fall into this category. Even before Pearl Harbor, the marriage rate throughout the United States increased as a result of the European War and the probability that the United States would be involved in it; this was particularly evident after the enactment of the Selective Service Act in September, 1940.[1] If we take this event as the decisive date, we find that 116 of the 200 couples covered by the study married after this date.

Out of these three possible choices, we selected the middle group for further analysis—*i.e.*, the 89 marriages entered into after Pearl Harbor. Table III shows the length of time of acquaintance of these couples prior to marriage. In 26 out of these 89 cases, no data were available. In only four cases, was the acquaintance one month or less; in 13 cases, it was less than six months; in 22 cases, less than one year. The average length of time of acquaintance in the 55 cases for which exact data were available, was eighteen-to-nineteen months. If we add the cases in which "life," "since childhood," or "several years" were given as the length of time of acquaintance, we arrive at an average of approximately twenty-two months. The statistical data for the control group do not include this item. Neither was it possible to find any general statistical data in the topical literature relating to length of time of acquaintance before marriage. To judge

[1] See "Marriages, Births, and Divorces," by William Fielding Ogburn. The *Annals of the American Academy of Political and Social Science*, Vol. 229, September, 1943. p. 22.

from purely general impression, it would appear that an average time of twenty-two months' acquaintance prior to marriage is not out of step with the general experience of the total married population.

Out of the 89 cases, 17 couples married with parental approval, nine did not, while for the remaining 63 no data were available. This figure is too small to lend itself to any analysis.

Number of Children.—Table IV shows the number of children of the 200 couples. Children of only the husband or only the wife by previous marriages and children born out

TABLE III. LENGTH OF ACQUAINTANCE OF COUPLES IN CASES OF WAR MARRIAGES

Length of acquaintance	*Number of couples*
Up to one month	4
1 to 2 months	1
2 to 3 months	3
3 to 4 months	2
4 to 5 months	3
5 to 6 months	6
6 to 11 months	3
1 to 2 years	13
2 to 3 years	7
3 to 4 years	8
4 years	3
5 years	2
"Several years," "since childhood," "life"	8
Not reported	26
	89

of wedlock by the wives to other men are not counted, even if they lived in the home of the couple.

Forty-five couples, or 22.5 per cent of the group under study, had no children, as compared with 29 per cent in the control group.[1] Seventy-three couples, or 36.5 per cent of the group under study, had one child as compared with 32 per cent in the control group.[2] There were two children in 25.5 per cent of the cases of the group under study (51 couples) and 20.7 per cent in the control group.[3] Three chil-

[1] See *Annual Report of the Municipal Court of Philadelphia for 1945*, p. 135.
[2] *Ibid.*
[3] *Ibid.*

dren had been born to 22 couples, or 11 per cent, in the group under study while the corresponding figure in the control group was 10 per cent.

The difference between the group under study and the control group are slight. It is significant, however, that the group under study showed a smaller percentage of couples with no children than the control group, and a higher percentage of couples with one child or two children. This reflects the wish of couples who are aware of impending separation because of the husband's induction or enlistment, and the possible death of the husband in combat, to have offspring.[1] This applies primarily to the "war marriages,"

TABLE IV. NUMBER OF CHILDREN OF 200 COUPLES

Number of children	*Number of couples*
None	45
1	73
2	51
3	22
4	3
5	2
6	1
7	1
8	1
9	1
	200

as is proven by the fact that in 46 out of the 73 cases of the group under study in which there was one child, the couple had been married less than four years—*i.e.,* since 1941 or later. Twenty-one of the couples who had been married less than four years had two children, and one had three children.

Military Service of the Husband.—Table V shows the year in which the husbands entered military service.

Voluntary enlistment was recorded in 26 cases, while in 174 cases induction of the husbands was either expressively mentioned in the court records or must be assumed.

One hundred and fifty husbands served in the army (including four in the army air corps), 42 in the navy, seven in the Marine Corps, and one in the Coast Guard.

[1] See Ogburn, *op. cit.*, p. 25, on the rise of the birth rate during the first few years of the war.

Overseas duty was recorded in 49 cases; in 110 cases mention was made that the husband did not serve overseas; and in 41 cases it was unknown whether or not the husband had performed overseas duty. Disregarding the cases for which no data were available, we arrive at a figure of 30.8 per cent (49 out of 159) for husbands with overseas duty.

How does this figure compare with the statistics for the entire military population? According to the biennial report of the Chief of Staff of the U.S. Army to the Secretary of War of September 1, 1945, the so-called "Marshall Report",[1] "our peak mobilization for the military services was 14,000,000." It can be assumed that this included about two million women in the various branches of the armed forces. This

TABLE V. YEAR IN WHICH 200 HUSBANDS ENTERED MILITARY SERVICE

Year	*Number of husbands*
1940	7
1941	17
1942	55
1943	63
1944	41
1945	1
Not reported	16
	200

seems to be confirmed by a statement in the New York *Times* of March 24, 1946, that in March, 1945—*i.e.*, shortly before V-E Day—there were about 12,200,000 men in the armed forces—8,300,000 in the army, 3,389,000 in the navy, 481,959 in the Marine Corps. According to a letter of the Adjutant General's Office of January 28, 1946, to the Public Charities Association of Pennsylvania,[2], approximately 7,300,000 army personnel served overseas from December 1, 1941, to August 1, 1945. To this we might add at least two million navy and Marine Corps personnel. Comparing 9,300,000 men who did overseas duty with a total mobilization of 12,200,000 men, we would arrive at a figure of 76.2 per cent. This is almost two

[1] See *The New York Times*, October 10, 1945.

[2] The writer is indebted to Dr. Arthur H. Estabrook, Secretary of the Public Health and Mental Hygiene Division of the Public Charities Association of Pennsylvania, for securing this information.

and a half times the percentage of men with overseas duty within the group under study.

The length of overseas duty, if recorded, ranged from one month to thirty-seven months. At least 23 of the 49 husbands with overseas duty had had battle experience; no data were recorded for the 26 others.

Out of the total of 200 husbands, 37, or 18.5 per cent, had served less than seven months, and 78, or 39 per cent, less than one year. No accurate comparison is possible for this item, since according to the letter of the Adjutant General's Office, such figures have not yet been compiled for the total armed forces. From general experience, however, it can be reasonably assumed that the percentage of men with short-service terms in the group under study is higher than the corresponding figures for the total armed forces.

Table VI shows the length of military service of the husbands.

TABLE VI. LENGTH OF MILITARY SERVICE OF 200 HUSBANDS

Number of months	*Number of husbands*
Less than one month	1
1 to 3 months	13
4 to 6 months	23
7 to 9 months	18
10 to 12 months	23
13 to 15 months	9
16 to 18 months	20
19 to 21 months	11
22 to 24 months	11
25 to 27 months	8
28 to 30 months	8
More than 30 months	28
Not reported	15
Not yet discharged*	12
	200

* This category includes two men with sixteen months, two men with nineteen months, one man with twenty-three months, one man with twenty-six months, two men with twenty-nine months, one man with thirty-six months, and one man with forty-five months of service at the time of filing of the complaint at court. In two instances, the length of service was not known.

Reasons for Discharge of the Husbands from Military Service.—Information about the reason for the husband's discharge from military service is based upon statements by the parties involved; it was not verified. In most cases it was obtained from the husband himself. There were a few cases,

however, in which it could be secured only from the wife, since the record did not contain any statement by the husband, who failed to respond to a letter from the court asking him to call for an interview, either because he chose not to respond or because he could not be located; unless a petition is filed and the case heard by the judge who issues a bench warrant, the husband's appearance cannot be enforced. Frequently, too, husband and wife did not use the technically correct terminology, either because they did not know it or because they were reluctant to use a phrase that they considered as carrying a stigma.

There were 38 discharges based on mental reasons and 14 based on physical as well as mental causes. They included all those instances in which the husband or the wife mentioned the official term "neuropsychiatric" (N.P.); those in which husband or wife cited "bad nerves," "nervousness," "nervous condition," and similar symptoms as the reason for discharge; and finally those in which the husband was examined by the psychiatrist of the court's medical department and was diagnosed as showing "battle fatigue," "war neurosis," and so on.

In 29 cases, "medical discharge" was mentioned without further specification; it can be reasonably assumed, particularly on the basis of the social history as contained in the court records, that about 40 per cent of these cases also belong in the category of mental or neuropsychiatric reasons.[1]

Thirty-seven husbands were discharged for purely physical reasons, 19 for service-connected disabilities (not mental), 10 because they had acquired sufficient "points," three because they were over-age, one for reason of dependency, and one for other reasons ("fraudulent enlistment"). Fourteen dishonorable discharges were counted; these included all discharges based on disciplinary reasons.

In 22 instances, the reason could not be ascertained, and in 12 cases, the husband had not been discharged at the time of filing the complaint at the court.

[1] According to a report of the National Mental Health Foundation (quoted in the *Philadelphia Inquirer* of May 6, 1946), 39 per cent of all those discharged from the army for medical reasons up to July 1, 1945, were unfit for duty because of mental or emotional ills.

Adding up these discharges—38 for mental reasons, 14 for physical and mental reasons, 12 so-called medical discharges (*i.e.,* about 40 per cent of the 29 thus classified) in which we can assume mental reasons, and 14 dishonorable or disciplinary discharges—we get a total of 78. Relating this figure to the total 166 cases of the group under study in which discharge had taken place at the time of filing the complaint at court and in which the reason for discharge could be ascertained, we can state that in 47 per cent of the cases, the reason for discharge was caused by or connected with some form of behavior disorder.

To compare again with general military statistics, according to the letter from the Adjutant General's Office previously mentioned, "to the present time (1–28–46) approximately 325,000 members of the army have been discharged by reason of Certificate of Disability Discharges for neuropsychiatric conditions, of which 220,000 were discharged for psychoneurosis." Since this refers to the army only, it would mean that out of the total number of army personnel (8,300,000) about 4 per cent were discharged for neuropsychiatric conditions. This figure might be questioned as too low; for instance, a report mentioned in the *Survey Midmonthly* of November, 1945 (p. 305) stated that "by the end of September 1945, 476,023 men had been released from the several branches of the armed services, with a medical diagnosis of psychoneurosis; they represented about 15 per cent of the 3,000,000 men who had been discharged up to that time." Whichever of these two figures we consider as being nearer to the truth, the percentage of such cases in the group under study far exceeds the figure in the general military population.

Court History.—In 167 of the 200 cases, the complaint or petition was filed by the wife against the husband. The immediate reason for domestic friction and the subsequent appearance of the wife at the court was "desertion and non-support" in 76 cases, "cruelty and non-support" in 23 cases, "failure to provide sufficient support" in 23 cases, "marital difficulties" in 35 cases, and failure to support after separation or divorce in 10 cases.

In 31 cases the complaint or petition was filed by the hus-

band. In this group there were 22 cases in which "marital difficulties" were cited as causes for domestic friction, while in nine cases desertion by the wife was specifically mentioned.

In two instances, applications were filed both by husband and wife. Both couples had been separated for a considerable time.

The category of "marital difficulties" contains a whole gamut of accusations and counter-accusations, such as "in-law" trouble, gambling, quarreling, drinking (58 cases), associating with other woman (40 cases), associating with other man (28 cases), cruelty to the child, threat to kill, money matters, laziness, nervousness, and sexual incompatibility. In 31 cases, the wife had left the husband "for cause."

The only data available for the control group, in this connection, refer to drunkenness as a causal factor in domestic friction. In the group under study alcoholism was cited in 58 cases (or 29 per cent); in the control group these cases amounted to 23 per cent.[1]

Out of 145 cases in which marriage took place before the husband's induction or enlistment, the case records in 106 cases, or 73 per cent of this group, indicated the existence of domestic friction before the husband entered the armed forces. That was concluded from the fact that either husband or wife or both, while being interviewed in the current case, mentioned that marital difficulties had existed prior to the husband's military service, or that other persons or agencies had reported it confidentially to the court. This does not necessarily mean that the friction had reached the point where wife or husband applied to the court for action. As a matter of fact, out of the total of 200 cases, in 57, or 23.5 per cent, instances previous applications had been made to the domestic-relations division of the court.

Out of the 167 cases in which the wife applied for court action, the object of the complaint or petition in 126 cases was the securing of a support order against the husband for herself and child or children; in 31 cases, it was only to discuss marital difficulties and obtain advice; and in the remain-

[1] See *Annual Report of the Municipal Court of Philadelphia for 1945*, pp. 132 and 143.

ing 10 cases, miscellaneous objectives were sought, such as custody of child, protection against the husband's brutality, and so on.

In 25 out of the 31 cases in which the husband was the complainant, the intention was to discuss marital difficulties; in four cases, custody of the child and arrangements to see the child were the purposes of the complaint; in two cases, the husband came to the court "only to make a statement for the record" as to his leaving the wife "for cause."

Finally, in the two cases in which both husband and wife applied to the court, the discussion of marital difficulties was the object of the one complaint, and arrangements for the husband to see the child, as well as financial arrangements, were the object of the other complaint.

As to the time of filing the application in relation to the discharge of the husband from military service, in 83 cases—*i.e.*, 44.2 per cent of the 188 cases in which the husband had been discharged from the armed forces at the time of the application—the time interval was less than seven months.

Disposition of the cases through formal court hearing was recorded in 59 cases; out of these, in 42 instances, an order was placed on the husband for support; in nine cases, the petition was withdrawn or dismissed; in seven cases there was continuance for further hearing; and in one case a bench warrant was issued.

One hundred and forty-one cases were disposed of without formal court hearing. In 45 cases, some kind of adjustment was achieved, either through conference of the interviewer with husband and wife, or through the visits of a probation officer at the home, or through reconciliation of husband and wife on their own accord. In 29 cases, no further court action was taken upon request of the complainant. In 40 cases, no further court action was taken for other reasons, for instance because the husband could not be located or because the case had been referred to another court, (*e.g.*, placement of children through the juvenile division of the court). In 27 instances, the case was still pending at the time of the study.

To summarize:

The following vital statistics are characteristic for the group under study:

1. The mean ages for husbands and wives in the group under study are lower than in the control group.
2. The percentage of couples in the group under study who were married less than six years is considerably higher than in the control group.

In the following respects the group under study shows only slight differences from the control group or the general population:

1. The percentage of couples with no children in the group under study is somewhat lower than in the control group, while the percentage of couples with one and two children is slightly higher than in the control group.
2. The mean-age difference between individual husbands and wives in the group under study is a little below the estimated mean-age difference between couples in the general population.
3. The racial composition of the group under study hardly differs from the racial composition of the control group.
4. The percentages in both groups of situations in which alcoholism was found to be a causal factor for marital difficulties differ only to a small degree, with a somewhat higher percentage for the group under study.
5. Even in the group of so-called "war marriages" the mean time of acquaintance before marriage cannot be considered as abnormally short.

In respect to marital history of the couples and to military service of the husbands, the group under study shows the following characteristics:

1. In almost three-quarters of those cases in which marriage had taken place before the husband entered the armed forces, there had been marital difficulties prior to the husband's induction or enlistment.
2. The percentage of husbands in the group under study who did overseas duty was about two-fifths of the

percentage of men in the total armed forces who did overseas duty.

3. The percentage of husbands in the group under study who were discharged for reasons of behavior disorder was very much higher than the percentage of such discharges in the total armed forces.

4. It can be assumed that the percentage of husbands in the group under study who served only a comparatively short time in the armed forces was higher than the corresponding figure for the total armed forces.

Conclusions

From these findings it appears that the group under study is composed of persons whose marriage under any circumstances—in war or in peace—was predisposed to encounter difficulties. As a matter of fact, the court records revealed that in a high percentage of cases, marital discord had set in prior to the husband's entering the armed forces. One reason for the marital failures might be found in the fact that—as the military history of the husbands shows—a high percentage of the husbands lacked stability to such a degree that they were not able to measure up to the exigencies of military life, and, therefore, did not serve for a long time, did not go overseas,[1] and were discharged for reasons of behavior disorder.

The findings indicate that the war experience tends to intensify already existing marital difficulties rather than to create new ones[2], or as Ernest R. Mowrer put it:[3] "For those marriage relationships in which little or no accommodation

[1] "Since many men are eliminated from the service or retained on duty in the U. S. because of psychoneuroses that became manifest during training or prior to shipment overseas, it is probable that in general the soldiers who were sent overseas constituted a more stable group than those who did not serve overseas." From "Enlisted Men with Overseas Service Discharged From the Army Because of Psychoneuroses: A Follow-up Study," by Lieutenant Colonel Norman Q. Brill, Mildred C. Tate, and Colonel William C. Menninger. MENTAL HYGIENE, Vol. 29, October 1945. pp. 677–78.

[2] See "The Veteran as Seen by a Private Family Agency," by Dorothy V. Thomas. *The Family*, Vol. 26, October, 1945. p. 204.

[3] In an article, "War and Family Solidarity and Stability," in *The Annals of the American Academy of Political and Social Science*, Vol. 229, September, 1943. p. 106.

has been achieved prior to the war, the hazards of family disintegration are accentuated'' by the war.

Any diagnosis of individual cases of this kind must naturally consider the war experiences of the husbands, but it must go beyond that in order to find the basic reasons for marital discord, so that, whenever feasible, psychiatric therapy or case-work treatment can be applied through the probation and medical departments of courts, mental-hygiene clinics, marriage councils, and other qualified agencies.

THE DEVELOPMENT OF MENTAL-HYGIENE CLINICS IN THE COUNTIES OF MARYLAND *

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FOR years the largest unmet need in the field of public health has been the need for psychiatric service to the community, both diagnostic and treatment. The lack of adequate facilities for such service has always been most marked in rural areas. These statements apply without exception to every state of the Union. It will be the purpose of this paper to describe how Maryland has attempted to meet this need in the counties and to outline future plans for dealing with this problem.

Although the first county mental-hygiene clinics in Maryland were organized in 1934, for years prior to this date many counties received some mental-hygiene service. From 1913 to 1916, Dr. William B. Cornell, of The Mental Hygiene Committee of Maryland, visited several counties and examined patients. From 1916 to 1927, Dr. Charles B. Thompson, executive secretary of the newly organized Mental Hygiene Society of Maryland, carried on and expanded these county visits. Dr. George H. Preston, of the state board of mental hygiene, held sporadic clinics in various counties whenever a special need arose, from 1928 to 1934. In addition to this, several counties referred patients to nearby psychiatric clinics. This service was given by psychiatrists in the various mental hospitals and in the clinics in Baltimore and Washington.[1]

It became apparent, however, that the transportation of patients to distant centers for diagnostic study was far from

*Presented at the Annual Meeting of the Medical and Chirurgical Faculty of Maryland, April 23, 1947.

[1] These clinics were notably the Phipps Clinic (Johns Hopkins Hospital), the Mental Hygiene Clinic (the Mental Hygiene Society of Maryland), the Washington Institute of Mental Hygiene (Washington, D. C.), the Sheppard and Enoch Pratt Hospital (Baltimore County), and Chestnut Lodge Sanitarium (Montgomery County).

satisfactory for several reasons. Many cases that needed study and treatment were not being sent to clinics. The study of mental problems, particularly those of children, can be carried on much better locally than at some distant clinic. The demand and need for psychiatric service in the counties was far greater than the clinic service available to them. Some counties were too distant to profit by services in the large medical centers.

This unmet need was studied by a committee of the Board of the Mental Hygiene Society of Maryland at the instigation of Dr. Ralph P. Truitt, the society's executive secretary. The chairman of this committee, Dr. J. H. Mason Knox, Jr., who was also the director of the bureau of child hygiene of the state department of health, called a meeting of psychiatrists, in February, 1934, to discuss how more adequate psychiatric facilities could be supplied to the rural areas of Maryland.[1] This meeting was attended by representatives of the Mental Hygiene Society of Maryland, the Johns Hopkins Hospital, the state board of mental hygiene, the Sheppard and Enoch Pratt Hospital, and three state hospitals. At this meeting nine psychiatrists volunteered their services, and the various counties of Maryland were allotted to these volunteers. Plans were laid for organizing county clinics and the office of the bureau of child hygiene was used as a central, coördinating agency. This office kept a file of the records of all cases seen, had a schedule of the clinics in the various counties, and served as an information center.

The county clinics varied markedly in the type of service offered. This was an inevitable result of service on a voluntary basis and was due partly to the marked differences in the training and experience of the various psychiatrists who served these clinics. The greatest variation was in frequency of clinic visits. This ranged from one to ten visits per year. Each clinic visit was for a full day. The clinics varied also in the type of study made. In some clinics the psychiatrist visited alone, did both psychiatric examinations and psychometric tests, and used histories furnished by health-department nurses. In other clinics the psychiatrist was accompanied by a

[1]See "Mental-Hygiene Clinics in Rural Maryland," by J. H. M. Knox and H. F. Shirley. MENTAL HYGIENE, Vol. 22, pp. 427-36, July, 1938.

clinical psychologist, who assisted with psychological examinations, and psychiatric social workers, who obtained psychiatric histories from relatives. Also, in some counties, many of the histories were furnished by social workers from the social agencies that referred the patients.

Each county served received some educational benefit from these clinics. Case conferences with social workers, teachers, nurses, health officers, and juvenile-court judges not only were useful in helping them solve individual problems, but served as well to improve their understanding of mental problems and to make them more aware of unmet needs in the community. Education in mental-hygiene principles was also furthered by lectures, committee meetings, and courses.

As is to be expected when psychiatric facilities are first introduced to an area, the problem most frequently encountered was that of mental deficiency and retardation in school work. In 1936, Dr. Knox wrote: "From the facts brought out in the clinics, two much needed developments are made strikingly apparent: the establishment of additional classes in the public schools for the education of exceptional children, and increased provision for the institutional care of children with greatly impaired mental development."[1] In 1937, he wrote: "As an indirect result of these mental-hygiene clinics, additional classes for exceptional children have been started in several of the counties."[2]

Reports of the state health department show that, between 1934 and 1941, 5,560 patients were examined, or an average of 740 patients for each full year. During the most active years, 1938 to 1940, over 900 cases were seen a year in about 140 clinic visits in 22 of 23 counties. Baltimore County was not included in this program, as it was able to use clinics in Baltimore. Averages showed that 88 per cent of the patients were white, and 84 per cent were under twenty-one years of age. About 40 per cent were referred by social agencies, 27 per cent by public schools, and about 10 per cent by county health departments.

These clinics were received with enthusiasm by the counties and were particularly appreciated by the health departments,

[1]In the Monthly Bulletin of the Maryland State Department of Health, April, 1936.

[2]In the Annual Report of the State Board of Health for Maryland, 1937.

the public schools, and the county welfare boards. Six of the counties organized county mental-hygiene committees and raised enough funds to pay for traveling expenses. In every county the need for more adequate service was glaringly apparent. In 1936, Dr. Knox stated: "That there is a great need in the counties of Maryland for a regularly organized examination service under the direction of experienced psychiatrists, for both children and adults, is evident from the findings at the clinics."[1]

I have selected the mental-hygiene clinic of Montgomery County to illustrate the method of organization and operation, because I was associated with this clinic from 1935 to 1941, and because at the present time Montgomery is the only county that supports a full-time clinic.

Montgomery County has many assets to facilitate the acceptance and use of the services of a psychiatric clinic. It is a progressive, growing community, its population having jumped from 49,000 in 1930 to 84,000 in 1940. Containing several of the suburbs of Washington, its population has a high average of wealthy and well-educated citizens. In addition, many well-trained psychiatrists reside in the county, most notably those connected with Chestnut Lodge, a private mental hospital.

At about the same time that other county clinics were being organized, a group of interested citizens wrote to the Mental Hygiene Society of Maryland asking that some clinic service be given to Montgomery County. In March, 1935, I met with a group of interested people and this group organized the Montgomery County Mental Hygiene Committee. The function of this committee was that of a local sponsoring group who could finance the expenses of a clinic, select cases to be studied, arrange the clinic schedule, provide quarters, advise regarding policies, and educate the local citizens regarding mental-hygiene facilities and needs.

The membership of the mental-hygiene committee consisted in general of representatives of social agencies, public and private, and lay and civic groups, as well as private citizens. The agencies represented (usually by the executive and a board member) were the welfare board, the Social Service League, the juvenile court, the school board, the health de-

[1]In the Monthly Bulletin of the Maryland State Department of Health, April, 1936.

partment, the social-service exchange, the county medical association, the department of public welfare, the Parent-Teacher Association, the Federation of Women's Clubs, the county commissioners, the Civic Federation, and the American Legion.

Early in its history the committee affiliated with the Mental Hygiene Society of Maryland and with The National Committee for Mental Hygiene. It held an annual meeting each January, at which time officers were elected and reports of activity and progress made. During the year, the affairs of the committee were conducted by an executive committee, consisting of the officers and the chairmen of the various committees. The active committees were Clinic, Institutions, Library, Membership, Program, and Interpretations.

Funds were raised for the committee on two occasions. In October, 1935, and in October, 1936, the proceeds of the Montgomery County Charity Horse Show were divided between the Social Service League and the mental-hygiene committee.

Beginning in April, 1935, I held monthly clinics in Rockville, ten months of each year. In these clinics I was always assisted by a clinical psychologist, Dr. Alice J. Rockwell, and occasionally by a psychiatric social worker. During each clinic visit new patients were examined, conferences were held with the referring workers or nurses, occasionally old patients were seen for follow-up or treatment interviews, and a meeting of the executive committee was attended.

In January, 1938, several psychiatrists residing in Montgomery County offered volunteer service to the mental-hygiene committee. This offer was accepted and a program worked out whereby each psychiatrist was assigned to some agency, most of them giving about a half day a week of their time. Some of this time was taken from private practice and some was salaried time donated by Chestnut Lodge Sanitarium. A different psychiatrist was assigned to each of the following agencies: the public schools, the health department, the juvenile court, the welfare board, and the Social Service League. In addition to these, a psychiatrist was assigned to handle emergencies, such as examining psychotics in jails, and a psychiatrist from Springfield State Hospital held a clinic in Rockville for paroled patients. These psychiatrists con-

tributed about three full days of time a week. Most of them also served on a speakers' bureau which was organized by the local committee.[1]

As a result of this rather elaborate program, which lasted for nearly four years, I spent less time in examining patients and more time in education, administration, and coördination of the various services. In successive years I gave two courses for the public schools, one to teachers and one to high-school counselors, and carried on other experimental projects.

In 1939, a serious attempt was made to get the Washington Community Chest to finance a full-time clinic in the county. This was not successful and the program described was continued through 1941. Although I left for active military service early in 1942, the county mental-hygiene clinic continued some activity until January, 1944, when a full-time clinic was organized and financed by the newly created Montgomery County Community Chest and Council. Dr. Paul Stevenson describes this clinic in his survey of the mental-health facilities of the Washington area.[2]

The clinic now runs on a budget of about $15,000.00, of which $2,000.00 is collected in fees. Its professional staff consists of both full-time and part-time people, and about 260 new cases are examined a year. Of these from one-third to one-half are treated. In the short period during which this clinic has functioned, a definite trend in the method of referring cases has been noted. Fewer patients are being required to be examined by the various official agencies, while more are being referred by physicians or are referring themselves for treatment.

Although the county clinics described above were, for the most part, discontinued during the war, Montgomery County is not the only county that holds mental-hygiene clinics at the present time. Seven counties now have regular clinics and two or three other counties receive occasional service.

Baltimore County established a mental-hygiene clinic in October, 1944. This has been financed primarily by Sheppard and Enoch Pratt Hospital, the Baltimore County Children's Aid Society, and the juvenile court. The county welfare board

[1] See "Psychiatric Service in a County." *The Health Officer* (United States Public Health Service), Vol. 3, pp. 285-97, February, 1939.

[2] Washington Metropolitan Health and Hospital Survey, 1946.

contributed support for a period. In this clinic a psychiatrist and a psychologist spend one day a week in seeing patients, mostly children, on a diagnostic basis. Over 100 new cases a year are seen.

Since 1945, the state board of mental hygiene, through the Eastern Shore State Hospital, has financed clinics in Cecil, Talbot, and Wicomico counties. Each county has a clinic one day a week.

Since 1946, the state department of health has financed clinics in Carroll and Anne Arundel counties. In Carroll County, a psychiatrist and a psychiatric social worker visit the county one day a week. In this clinic the psychology department of Western Maryland College has coöperated in doing some mental testing. In Anne Arundel County a psychiatrist visits two days a month, seeing mostly children referred by the public schools and the health department.

The state department of health also arranges an occasional emergency clinic in Charles and Calvert counties at the request of the Maryland Children's Aid Society. Prince George's County refers patients to the various clinics in Washington because that county contributes to the Washington Community Chest.

In the remaining thirteen counties many psychiatric patients are seen diagnostically by the county health officers and by the pediatric consultants of the state department of health.

In January, 1947, the Committee on Medical Care of the Maryland State Planning Commission, in an interim report submitted to the governor, stated:

> "Prior to the outbreak of war the Mental Hygiene Society of Maryland sponsored clinics held at irregular intervals in various Maryland counties. This experience indicated a widespread need for such service, as well as an increasing public demand. It was impossible to continue these clinics during the war, but after the cessation of hostilities the subject of organized provision of mental-hygiene clinics throughout the state was taken up, and tentative agreement was reached between representatives of the Mental Hygiene Society, the State Board of Health, and the Board of Mental Hygiene, that the administration of such clinics would most effectively be undertaken by the State Board of Health."

The executive committee discussed this problem on November 15, 1946.

"It was the consensus of the meeting that the State Board of Health, through its state-wide organization of county health officers and nurses, was the agency best qualified to administer a non-institutional mental-hygiene service, utilizing, for professional aspects of the work of the clinics, physicians designated by the Commissioner of Mental Hygiene, as well as those recommended by the Mental Hygiene Society of Maryland."

On December 12, 1946, the executive committee presented these conclusions to the committee on medical care, which agreed unanimously to recommend such a program to the state planning commission.

"Certain Federal funds now are available for matching State and local funds in the support of non-institutional mental-hygiene service. A service of this type would be very much akin to that now conducted by the State Board of Health in other fields of illness, such as tuberculosis, venereal disease, orthopedics, obstetrics, etc. Under existing Maryland legislation, the Board of Mental Hygiene is charged with the responsibility for the care of the mentally ill, and under the provisions governing the Federal funds it is likely that Maryland's share would necessarily go to the Board of Mental Hygiene, whereas this out-patient program might most logically be administered as a part of the present out-patient service of the State Board of Health.

"Therefore, the Committee on Medical Care recommends that: A division of mental-hygiene be created in the State Department of Health; and further that legislation be enacted necessary to permit the State Board of Health to receive and expend Federal funds to be matched with local funds in the support of a mental-hygiene service for out-patients, the professional phases of which are to be integrated as closely as possible with the professional programs of the State mental hospitals."

The federal funds referred to are not yet available, but are contemplated in the National Mental Health Act passed by the 79th Congress, in 1946.

In May, 1946, the state board of health created a division of mental hygiene to act as the state mental-health authority empowered to receive federal funds on a matching basis. When these funds become available, the division of mental hygiene plans to organize or stimulate the organization of clinics, particularly in the counties that have no such service. At present the mental-hygiene activities described above are carried on by Dr. Edward Davens, Chief of the Bureau of Child Hygiene, pending activation of the division of mental hygiene.

I would like to close with a few comments on the future development of psychiatric service for the counties of Maryland. It is almost certain that specialists in psychiatry will not en-

gage in private practice in the rural areas. For this reason subsidized mental-hygiene clinics are the only practicable means for supplying a service that is needed by practicing physicians as well as by agencies such as health departments, public schools, and juvenile courts.

Paternalistic subsidies provided by federal and state funds are useful in demonstrating how a need can be met, but continued reliance on these funds represents an unhealthy tendency. It is far more healthy for a community to organize itself, study its own needs, and determine what it can do to meet these needs. The experience of the Montgomery County Mental Hygiene Committee illustrates this principle. It is true that Montgomery County is not typical of every county in Maryland. However, it is my contention that there is no county which, if properly organized and aware of the needs, cannot contribute to a part-time clinic service at least. On the basis of population, Allegany and Garrett counties could easily support a full-time mental-hygiene clinic. Similarly groups of two to four counties could unite to support clinics that would divide their time between the counties. Funds could be raised in a drive, as is done for any private agency, or they could be raised by allocating funds from the budgets of the agencies that use the clinic most, such as the welfare board, the health department, the public schools, the courts, and so on.

It might be objected that such a program requires more unity and coöperation than these groups or these counties habitually show toward one another. The experience in Montgomery County, and other counties in which mental-hygiene committees have been formed, has shown that such an organization results in more unified thinking about common unmet needs, and more coöperative effort to meet these needs, than had ever been true before. People usually want to coöperate and to do the sensible thing if they are given sensible projects to support.

The state department of health contemplates a modest beginning in the near future. At no time will funds be sufficient to supply adequate service for every county, but the organization of part-time clinics will be encouraged and aided. This program would certainly be advanced and hastened if in each

county the interested citizens could organize a local sponsoring committee. Such a committee would be useful in determining the need for local clinic service, in providing quarters, and in advising regarding policies. Dr. Davens, of the state department of health, tells me that he will be glad to advise any local group regarding the formation of such a committee.

It is my opinion that this program as planned offers sound progress toward the objective of improving the mental health of the citizens of Maryland.

STATE-HOSPITAL PSYCHIATRY: AN EVALUATION

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ANY one who, on the basis of his experience, is impelled to criticize unfavorably certain aspects of the state-hospital system cannot overlook the difficulties involved. Of these, three are outstanding:

First, there is the possibility of being erroneously classified as one of those individuals who are currently indulging in sensational, superficial, and purely destructive criticism of the mental hospitals.

Second, there is the danger of reiterating unnecessarily the criticism and recommendations that have been reviewed at great length for the past fifty years at the yearly meetings of the American Psychiatric Association, beginning with Weir Mitchell's address criticizing severely the administrative side of the mental hospital, and ending with the recent constructive criticism and suggestions made by the Medical Director of the Division of Mental Hygiene, United States Public Health Service, Dr. Robert H. Felix.[1]

Third, there is the possibility of error in drawing conclusions and making generalizations from limited personal experience. The writer has studied and worked in only two institutions of the Massachusetts Department of Mental Health. One was a large teaching hospital and research center, with an admission rate of over six hundred patients a year. The other was a smaller, non-teaching hospital, with an admission rate of less than three hundred a year. I have also attended the seminars and lectures given by the department of mental health in two other large teaching hospitals, so I had ample opportunity to form an opinion of the type of psychiatry that has been taught theoretically to the practicing physicians in these institutions, and had an opportunity also to compare the theory expounded to the institution physicians and the actual type of psychiatry that has been practiced in these institutions.

[1]See "Psychiatric Plans of the United States Public Health Service," by Robert H. Felix. MENTAL HYGIENE, Vol. 30, pp. 381-89, July, 1946.

In view of the fact that Massachusetts is considered one of the training centers for psychiatrists for the entire country, and that the Massachusetts system of the department of mental health is considered liberal, humane, and up to date, a generalization on the experience in this state should be considered justifiable, objective, and without prejudice against the other state hospitals in the country.

I intend to limit my observations primarily to the working conditions and mental atmosphere in which a state-hospital psychiatrist lives and breathes, and the hazards to which he is exposed. I do not intend to enlarge on the quality and quantity of food, services, and general medical care that the patient in a state mental hospital receives. I think it is enough to state that the budget allowed by a state legislature is between eight and ten dollars a week per capita. When one compares this with the present cost of forty or fifty dollars a week per capita in an active general hospital, one should not be terribly shocked to find that a state-hospital is still in the transition period from an "asylum" to a hospital. From my personal experience, I feel that the state institutions are run humanely, and with no gross physical abuse to the patient, but with too much emphasis upon economy.

The biggest problem of the state institution is to protect its patients from psychic trauma at the hands of psychiatrically untrained attendants, and to give patients the benefits of the combined teamwork in psychotherapy, chemotherapy, hydrotherapy, and shock therapy now available.

With the introduction of shock therapy in mental hospitals, the general atmosphere of defeatism and hopelessness that prevailed in the old custodial institutions has gradually begun to disappear, and the physician working in the institution has begun to feel a greater satisfaction in his work. The discharge rate of state hospitals has practically doubled—from 25 per cent to 50 per cent in acute cases—and now compares favorably with the discharge rate of the private mental hospitals of fifteen years ago. With the combined form of therapy now available, 80 per cent of acutely ill patients suffering from a functional psychosis can be brought under control in a comparatively short period of time, and discharged back into their communities, if teamwork of trained medical personnel

is obtainable for these patients both in private and in state hospitals.[1] Unfortunately, the introduction of massive shock treatment into the state hospital has led indirectly to the neglect of other forms of therapy.

The neglect of the opportunity to learn and to practice psychotherapy of all forms in the state hospital has made the state-hospital psychiatrist feel inferior to his extramural colleagues, and has been one of the chief reasons for the recent mass exodus of psychiatrists from the state-hospital service. Some of them have joined the staffs of Veterans Administration hospitals, with the hope of finding there the possibility of working in a more optimistic atmosphere, and of doing teamwork that combines all types of therapy for the benefit of the acutely ill veterans. Others have left for private mental hospitals, and some have actually gathered enough courage to acquire a portable electric-shock machine and go into private practice.

With the introduction of shock therapy into the institutions, it was predicted by the psychoanalytic group that the future of psychiatry would be ruined and that the effect on the thinking of the hospital psychiatrist and on his sense of moral values would be disastrous. Roy R. Grinker stated:

> "The avidity of interest aroused, and the rapidity with which the use of insulin and metrazol treatment spread into every corner of this country, from university clinics to state hospitals, attest a certain preparedness and eagerness of the rank and file psychiatrists for an organic approach to psychosis. Shock treatment has livened up the mental hospitals and psychiatrists once again. They have also served to redirect interest to the old hopeless schizophrenic cases. But interest in the uncovering of basic psychological causes has decreased, for the busy psychiatrist now hardly waits for the patients to undress in his hospital before shocking them into insensibility."[2]

H. S. Sullivan carries the same idea even a step further in the statement:

[1]See "Electric Convulsive Therapy, with Emphasis on Importance of Adequate Treatment," by L. B. Kalinowsky *(Archives of Neurology and Psychiatry,* Vol. 50, pp. 652-60, December, 1943). See also "Outcome in Dementia Praecox Under Electric Shock Therapy, as Related to Mode of Onset and to Number of Convulsions Inducted," by L. Lowinger and J. H. Huddleson *(Journal of Nervous and Mental Disease,* Vol. 102, pp. 243-46, September, 1945), and "Three Years' Experience With Electric Convulsive Therapy," by Jacob Norman and John T. Shea *(New England Journal of Medicine,* Vol. 234, pp. 857-60, June 27, 1946).

[2]See "Course of Depression Treated by Psychotherapy and Metrasol," by Roy R. Grinker and Ellen V. McLean. *Psychosomatic Medicine,* Vol. 2, pp. 119-38, April, 1940.

> "The current era of state hospital psychiatry may be considered as beginning with the eruption of *insulin shock* as a 'cure' for the schizophrenic psychoses..... When the 'treatment' of victims of severe mental disorder by diffuse decortication and destruction of some of their human abilities is sanctioned on the ground of social expediency, and all other methods of therapy are discarded as impractically difficult, one may well be concerned for psychiatry."[1]

From personal experience, I think that this critical attitude toward shock therapy expressed by the psychoanalytical group was unjustified, and that the dark picture of the future of the state-hospital psychiatrist was grossly exaggerated. What did really happen was that the emphasis was removed from a theoretical, descriptive psychiatry, from speculations about the etiology of psychoses, and was turned toward therapeutic, utilitarian psychiatry; and with this came a great desire to make use of all available methods of therapy at the same time.

Shock therapy greatly increases the number of patients in state hospitals who are amenable to some form of psychotherapy. On the other hand, new forms of short analytic therapy have recently been introduced, and more and more experience has been gained in the practice of group therapy with psychotics. We have learned from Fromm-Reichmann's work[2] that schizophrenics are approachable through psychotherapy and that the analytical couch and free association are not absolutely essential to the practice of Freudian psychiatry. Realization of the possibilities now available for efficient treatment of the acute affective psychoses has made the state psychiatrist realize that he cannot work or fulfill his duties to the patient in a setting that is half-hospital, half-asylum.

The question whether psychotherapy is an essential adjunct to shock therapy in the treatment of an affective psychosis has been debated for years. The committee on shock therapy of the American Psychiatric Association recommended that shock therapy should be only a part of a therapeutic program which might include active individual psychiatry, group therapy, and occupational therapy. The psychoanalytic psychiatrist considers shock therapy an adjunct to psychotherapy. Grinker states:

[1] In an editorial in *Psychiatry*, Vol. 6, pp. 228-29, May, 1943.

[2] See "Recent Advances in Psychoanalytic Therapy," by F. Fromm-Reichman. *Psychiatry*, Vol. 4, pp. 161-64, May, 1941.

> "The major obstacles of psychotherapy of depressed patients is the strong repression of all but the self-punishing tendencies. Shock therapy influences this resistance and repression to prevent release of expressed feelings and impulses with motor activity. A modified psychotherapy afterwards will bring about significant changes in the basic emotional attitudes; after the fifth or sixth convulsive treatment there is a dramatic outpouring of repressed material which can be dealt with psychotherapeutically." [1]

On the other hand, the confirmed organicist considers psychotherapy superfluous and a luxury only. Kalinowsky considers that one can get optimal results from intensive shock therapy with no psychotherapy in affective psychosis, and only in the psychoneuroses does he advise a combined course of treatment of shock therapy and psychotherapy.

From my own experience, I feel strongly that the central core of psychiatry is psychotherapy, that a certain minimum of psychotherapeutic reëducation is absolutely essential for every shocked patient before he is ready to meet his old environment. If he does not get his psychotherapy from the hospital psychiatrist, he is getting it from attendants on the ward, from other patients, or from his relatives. The emotional experience acquired in his therapeutic relation through his transference is an important factor in his reëducation.

The therapeutic interview helps the patient to meet the demands of the outside world, and makes his first steps toward reality easier. The dynamic of shock therapy is mainly to suppress the acute symptoms. Through psychotherapy the patient has an opportunity to express and to verbalize his psychogenic problems, to gain some insight into his sickness, and to avoid the old patterns of behavior that caused his main difficulties in interpersonal relationships. I believe that, with combined shock therapy and psychotherapy, the patient's gains are more lasting. In my experience, the number of shocks required, if combined with psychotherapy, are less than if one relies upon shock therapy alone. The abundance of psychogenic material produced by the patient after the fifth or sixth shock relieves him greatly and is very instructive to the psychiatrist in the dynamics of his case. The therapeutic relationship established between patient and physician during the interviews is of great value to the patient and

[1] See "Psychological Observations in Affective Psychoses Treated With Combined Convulsive Shock and Psychotherapy," by N. A. Levy and Roy R. Grinker. *Journal of Nervous and Mental Disease*, Vol. 97, pp. 623-37, June, 1943.

lasts long after he returns to his home. He feels that he can return to his physician for advice and education if he meets new difficulties in facing reality. The mechanical massive shock therapy will be, for years to come, the practical form of therapy for state hospitals. However, a combination of this form of therapy with the modified short uncovering therapy for the individual, or in group forms, will greatly benefit the patient and the institutional psychiatrist, and will convert the existing asylum-hospital-institution into an active psychotherapeutic institution.

There are other factors that contribute to the ambivalency of the practicing physician in the institution and to the difficulty of living up to the expectations of the lay public and of his colleagues. One is the proportionately large number of patients admitted who are in the terminal stages of organic brain disease and who require a great deal of somatic medical care and give very little opportunity for practicing psychosomatic medicine. These cases require a "working-up" for diagnostic purposes and for the purpose of records. They tax the limited resources of nursing care to the maximum. As high as 35 per cent of the admissions to state hospitals are senile psychotics and patients suffering from cerebral arteriosclerosis. These patients come from private hospitals, rest homes, and private homes when they become so untidy, restless, and unmanageable that they need either restraint or constant supervision and nursing care. With the introduction of penicillin and the sulfa drugs and good care, these patients last for months in the hospital, and give the physicians an opportunity to practice somatic medicine only.

The police supply another group of patients for the state hospital, mainly for observation and diagnosis, with very little opportunity to establish a real therapeutic doctor-patient relationship, and they, too, require a regular work-up for the sake of the records. These are chronic alcoholics with or without psychosis. The majority of them clear up sufficiently during the observation period to make it unnecessary to require regular commitment, and they are discharged without any attempt on the psychiatrist's part to get at the real dynamics of their underlying severe compulsive neurosis.

These patients present an unique problem and challenge for state-hospital psychiatrists. The alcoholic patient resents

the idea that he is insane and belongs in an institution. He insists on more privileges than the other patients have, and openly challenges the state psychiatrist: "What do you have to offer me as a cure for my alcoholic addiction? If you keep me here ten years, this is no guarantee that I won't drink when I leave." And very soon he becomes extremely cynical and critical. He considers the psychiatrist a jailer, and is ultimately released without obtaining special therapy. He knows that there are now special conditional-reflex treatments and psychotherapy of the type of Alcoholics Anonymous, and yet he is not offered the benefits of any of these treatments in the state hospital. As long as alcoholics are committed to state hospitals, they should be offered all forms of special treatment available.

The psychopaths, with their habitual asocial behavior, come from the courts, or from jail, as "guests" for thirty days, for diagnosis only, and give considerable work to the psychiatrist, with little opportunity for psychotherapy of any kind. Feebleminded individuals and epileptics come to the state hospitals as "guests" during their psychotic episodes for custodial care and are returned to their homes or institutions as soon as their acute episodes are over.

Patients suffering from syphilis of the central nervous system come to the state hospital for specific anti-syphilitic treatment and require a great deal of laboratory work and careful study for diagnostic purposes, and for selection of the specific treatment needed—fever or malaria combined with chemotherapy.

Anywhere from 40 to 45 per cent of the state-hospital population suffer from psychosis with organic brain disease of one form or another, requiring somatic medical treatment primarily, and offer the psychiatrist very little opportunity to experiment and to learn to give individual deep psychotherapy.

The second biggest factor in the prevailing depressive institutional atmosphere is the chronic schizophrenic, the long-forgotten man who went there because of his tendency to isolation, and who creates a dull, apathetic, hopeless atmosphere in the state hospital. The psychiatrist has to fight hard not to be engulfed in it himself. These patients are the old

burned-out schizophrenics who have been in the hospital anywhere from two to fifteen years, who perform a great deal of the labor that keeps the institution going—in the laundry, the kitchen, the cafeteria, or on the farm—and who make it possible for the state hospital to exist on its meager budget. They dull the intellect and flatten the emotions of the medical personnel, and lower the standard of psychiatry in the state hospital to that of custodial care.

These chronic cases are really victims, not only of a schizophrenic process, but of the old custodial care that existed up to the shock-treatment period. The acute schizophrenics treated now with combined shock and psychotherapy leave a very small residue in the hospital. From the point of view of dollars and cents of the taxpayers' money, it would be much more economical to spend $50 a week for the new patient during the first six months or year, and have him become a self-supporting individual, than to keep him in the hospital ten or fifteen years at $10 a week.

But it is not a question only of lack of funds, lack of personnel, or lack of beds that is responsible for the inadequate psychiatric treatment that patients received in the state institutions. The fact is that in the larger teaching hospitals not much more psychotherapy is given to the individual patient, and the results, as far as discharge rates go, do not differ greatly from those of smaller hospitals with smaller staffs. The problem is much deeper, and goes to the root of things and to the basic philosophy of psychiatry practiced. The theory and practice of psychiatry in the state hospital are still leading an isolated existence. When teaching or research becomes the center object in an institution, the patients indirectly suffer by it. Shock therapy given to an acutely ill patient within a week after his admission may not be very scientific dynamic psychiatry, but it helps to shorten the acute psychotic episode and saves the patient from many of the institution's hazards, in many instances from the biggest hazard of having to remain in the institution for life.

Long years of scientific research into the etiology of schizophrenia, along the lines of biology, bio-chemistry, and endocrinology, surely deserves all due credit, but so far it has brought very little help to the patient or to the patient's

family. Shock treatments were not in any way the result of these long years of research. At the same time, research into the various forms of psychotherapy, individual and group, suited for psychotics, was neglected. The ambivalency toward psychotherapy for psychotics that exists to-day in the training institutions is responsible largely for the state psychiatrist's inferiority feeling, and the critical attitudes toward him of his extramural colleagues, the so-called informed public, and the patients' relatives.

The skeptical, cynical, and ambivalent attitude toward the psychotherapy of psychotics is the chief factor that faces the psychiatric student in the state hospitals. He is instructed in the theory of psychopathology, psychobiology, and psychodynamics, and is introduced to the conceptions of Freudian dynamic psychiatry, but when it comes to practice, he is practicing descriptive, diagnostic Kræpelinian psychiatry. His chief work is working up cases for diagnosis and doing progress notes, and he spends hours keeping good records which are of little value to the patient. Every institution is very proud of its good records. In time the record becomes a substitute for the patient. We study the record instead of allowing the patient to establish rapport with the physician. The longer the patient stays in the hospital, the bulkier the record becomes. It contains records of breaking windows and rules, and this is the material for future "research." More time is spent on discussing the patient's case, recording accidents and temper outbreaks, than is actually spent with him in a constructive, therapeutic doctor-patient relationship.

A negative attitude toward many types of patient is inculcated in the physician who begins his apprenticeship in a state hospital. It is considered a waste of time to attempt to give therapy to a paranoid patient, or to a psychopath, and since the introduction of shock therapy, there is no need of "wasting time" with depressed patients, as they get well with shock therapy alone. The busy practitioner in a state hospital can easily rationalize and find an excuse for the inability to obtain suitable cases for psychotherapy. (As a matter of fact, the writer had good results from combined shock and psychotherapy in old paranoid schizophrenics.) Many hospital physicians are definitely inhibited in their effort to do psycho-

therapy on patients as soon as they are labeled "dementia præcox" at a staff conference.

In time of staff shortage, psychotherapy is the first form of therapy eliminated, as if it were a luxury to be indulged in only after the progress notes had been made out, the antisyphilitic treatment administered, the gynecological and eye clinics attended, and clysis given to the senile. Interviewing and appeasing the patient's family and attempting to give them psychotherapy is always ahead of giving psychotherapy to the patient.

Some hospitals have no facilities at all for giving psychotherapy, and the constant ringing of bells for doctors makes it practically impossible for them to concentrate on their interviews. The psychiatrist is also too often influenced by the administrative side of the hospital. He must always consider first the reputation of the institution; he must not displease the judge who sent in the patient, or the chief of police of the town from which the patient came and is to return; and he must not risk any early discharges. Safety of the public comes first; the peace of the family, second; the interests of the patient, last.

The psychiatrist is made to fear the patient and to be cautious about exposing himself unnecessarily in personal interviews, because some patients are unpredictable, impulsive, and treacherous. Therefore, when a patient continues to ask for a private interview, it is granted reluctantly because of the possibility that he may have paranoid ideas toward the interviewer, and may attack him. The young physician cannot help being influenced by the negative attitude toward psychotherapy of some teachers of psychiatry. Dr. Myerson, for instance, has made the statement:

> "No matter what the value of psychoanalysis may be in the treatment of neuroses, it has been of no value whatsoever in the treatment of schizophrenic and manic-depressive psychosis. Shock treatment at present is the only means of remarkably changing the mental state in schizophrenic and manic-depressive psychosis."

The belief in psychotherapy in the teaching state hospital in which a research project on schizophrenics has been going on for twenty years is also very weak. They teach Freudian psychodynamics and advocate deep therapy, but very little instruction is given to the young physicians as to how to

practice psychotherapy. Group therapy was experimented with for a couple of years, but was never considered an integral part of the research program and was dispensed with. Considerable lip service is given to psychotherapy, but there is a great deal of skepticism and nihilism prevailing in the atmosphere of state institutions toward the psychotherapy of psychotics. There is a feeling that if one is to carry on psychotherapy it must be by means of an orthodox Freudian technique given daily. As this is obviously impracticable because of the number of patients per physician, the patient receives custodial therapy and shock therapy only.

The lack of teamwork is felt constantly. Especially does one feel the lack of a real functioning rehabilitation service. Many of the so-called chronics, the forgotten men, are capable of functioning at a certain level in the community with a certain amount of supervision, but are unfortunate in that their family constellation has changed during their long hospitalization, and there are no relatives to help the patient take his first step toward rehabilitation when he is finally ready for it. These are the patients who do most of the work to keep their institution running economically, but who, from a psychiatric point of view, do not belong in the institution any more. The writer has a strong feeling that 20 per cent of the chronic schizophrenics could be rehabilitated to a degree of self-support at the existing high price for unskilled labor. Of course we have the same old problem and the same old answer —lack of properly trained personnel in the social-service departments.

Placement of the patient in family care has been recognized abroad and in this country as an important therapeutic measure. Many of the older patients would be much happier in a private family, where they could do a little supervised work and help cover part of their keep, the rest being paid for by the state. But our economical state laws allow only $8 per week for family care per patient. At the same time, the department is very particular about a suitable house and room for the patient. The house must be no fire hazard, and must have good bathroom facilities, and there must be no drinking in the family. The result is that only 4 per cent of the total hospital population has been placed in private homes. The

hospital psychiatrist often feels very much frustrated when he sees that his patient has improved sufficiently to leave the hospital and yet stays on months and years because of lack of rehabilitation facilities.

The legality and formality that attend the admission of psychotic patients to the hospital are a great source of annoyance to the state-hospital psychiatrist. A police officer or a physician can send in a patient on ten days' observation as an emergency case, with or without the consent of the patient's family. The patient is studied during the ten days and perhaps is found to be committable. For the commitment we need the approval of the family and the O. K. of two general practitioners, to verify the psychiatrist's recommendation. If they disagree, the patient cannot stay.

The procedure for the release of the patient is even more difficult and complicated. Under the state law, the responsibility of releasing a committed patient rests with the superintendent of the hospital. The superintendent does not have to share this responsibility with the rest of the staff if he does not want to. If he takes his responsibilities very seriously, he will be "careful" about releasing patients who show openly aggressive tendencies during the acute episode of their illness, because of the possibility that they may become potentially dangerous to themselves and to the public. This type of patient is released very cautiously, in spite of the fact that the acute symptoms have cleared up quickly under shock therapy, and that, for therapeutic purposes, the patient should be tried outside as soon as possible. The improved patient, his family, and the psychiatrist are powerless and frustrated and are compelled to wait until the conservative old custodial type of administrator is ready to risk the reputation of his institution by releasing the patient. The fear of suicide and homicide weighs so heavily on the shoulders of the superintendent that often he prefers to keep an improved patient months longer in the hospital, and risk losing all that the patient had gained by shock therapy, rather than chance a premature release and the possibility of criticism of the institution.

The hospital administration often "infects" the patient's family with this fear of potential dangers, and in such cases the family becomes reluctant to take the patient out, and

often demands of the psychiatrist a guarantee that the patient will not relapse again in the near future. The administrators often are much prouder of their low readmission rate than of their high discharge rate.

CONCLUSION

An attempt has been made to evaluate critically from personal experience the task at present facing the state-hospital psychiatrist. The state mental hospital is doing a tremendous amount of psychiatric service in the community and has no choice about selecting patients. The patients with organic brain disease require primarily a great deal of somatic therapy and nursing care. The existing old buildings, small hospitals where there is no separate acute-service wards, and no facilities for training medical personnel, plus the very limited budget for the care of such patients, make the life of an enlightened psychiatrist unbearable. His chances for experimenting with psychotherapy with individuals or groups is very meager, and he is in danger of regressing to a point where he is satisfied with shock therapy and custodial therapy.

The introduction of shock therapy into the state hospital brought with it a more hopeful attitude toward the therapy of the psychotics. If this hopeful attitude is to be kept up, an opportunity must be created for the institutional psychiatrist to establish rapport with his patients through some form of psychotherapy. A form of federal-state coöperation for the improvement of the hospital-asylum plants, and toward a better education and training of the medical personnel, will bring about a situation in which the patient in a public hospital will receive an adequate amount of combined shock therapy and psychotherapy equal to that available in private hospitals at present.

The emphasis and center of attention must always be the patient. The teaching-training and research programs must never become the center of the active hospital. Only large institutions with a large admission rate, and with a separate acute ward, are fit for training purposes. The physician who is apprenticing in psychiatry should have at least a year's experience with psychoneurotics, and should have learned to establish therapeutic relationships with his patients before he is exposed to state-hospital work with psychotics.

MENTAL-HYGIENE PROBLEMS IN A WELL-BABY CLINIC*

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MENTAL disease is a category of the same type as communicable disease. It includes many clinical entities. One does not, as a rule, launch programs against communicable disease in general, but against some specific infection, such as diphtheria or smallpox. Mental hygiene is only beginning a few tentative specific programs; there are some clinics for alcoholism, epilepsy, and juvenile delinquency, but, in general, the attacks are on a very wide front. We are in about the same stage of development in our science as was epidemiology when hand-washing and the fight against the common drinking cup were the bases of programs.

This paper is a report of an effort in the mental hygiene of behavior disorders in children. The relationship of this effort to the control of any other entity included in the generic term, mental disease, is left as an open question.

In the Eastern Health District of Baltimore, an attempt has been made to furnish mental-hygiene service primarily in connection with well-baby clinics. Cases are received in two ways: first, they are seen routinely—that is, no one has complained about them at all; secondly, cases are seen about whom the pediatrician, the nurse, or the parent has some definite complaint for which service is requested.

The items of behavior about which mothers are concerned, when given opportunity to complain, include temper tantrums, breath-holding, refusal of food, finger-sucking, masturbation, night terrors, and the like. In the cases brought by mothers

*Presented before the Maternal and Child Health Section of the American Public Health Association at the Seventy-fourth Annual Meeting, Cleveland, Ohio, November 12, 1946.

at the suggestion of the nurse or the pediatrician, the complaints are the same, but the list also includes more serious items, such as slow development or fits. The public-health nurses in the Eastern Health District are not specialized, so that they may refer older children to the clinic in connection with their duties as school nurses.

A listing of items of concern in a mental-hygiene service does not give the flavor of the individual case or any concept of methods for obtaining data or for dealing with them after they are in hand. For these purposes the presentation of individual cases is necessary. In reviewing the material, it appeared practical to present illustrations of two clinical groupings of cases: first, cases in which both mother and child were essentially normal personalities; second, cases in which the child seemed to be behaving in essentially normal patterns, the basic problem of management appearing to be a pathological personality pattern in the mother.

In this classification of cases, the words "normal" and "pathological" are used in referring to the personality. Admittedly, these terms are hard to define. It is hoped that the context will make their meaning clear for the purposes of this discussion.

The first case shows the development of a normal child in a relatively normal situation. The mental hygiene consisted in relieving the mother's anxiety when it appeared and, by anticipatory guidance, preventing the appearance of anxiety during the child's development.

Patsy S. was first seen at the age of fourteen months. When asked if she had any problems with her child, the mother said, "I can't get her broke—that's the only trouble. I've tried and tried." She referred to toilet training. Patsy was the only child of a twenty-year-old mother who had been married after she had become pregnant and who had had prolonged vomiting and a toxemia. She had made a half-hearted attempt to nurse her baby, but after a week switched to a bottle, explaining, "My milk must have been bitter." The child's appetite was good and her development normal, walking occurring at thirteen months and eight teeth being present at fourteen months.

Toilet training had started at four months and from six to eight months of age had seemed successful so far as bowel function was concerned, but then there had been a complete relapse. The mother worried about her lost efforts, though she did not punish the child for the failure. Occasionally there was constipation which was relieved by milk of magnesia. There were temper tantrums, the child lying on the floor screaming and kicking about once a day, "when she doesn't get her way." While the mother was not

too disturbed by these tantrums, the father complained that they "got on his nerves." There was a tendency to pica, the putting of unsuitable articles in the mouth.

The mother was reassured that the success of toilet training at six months had been largely luck and that the child was only now reaching the point at which training efforts would be effective. She was advised not to rush the child in the training and not to expect real success until about the age of two. It was suggested that fruit juices would relieve the constipation, and that less pressure on the toilet training would help prevent it. The mother was congratulated on her handling of the temper tantrums and encouraged to explain to her husband that this was part of the child's learning to handle situations that wouldn't always go the way she wished during her growing up. The pica was discussed in relation to lead paints, but supervision seemed adequate to control the tendency.

Eight months later, at twenty-two months, the bowel training was complete, and the mother could say with some satisfaction, "I have her broke." Bed-wetting continued, and occasionally in the daytime, when playing outside, she wet her clothes. Constipation had disappeared. The tantrums remained, but were shorter. The mother said, "I just look at her and walk away and then it's all over." Again the normalcy of the temper tantrums was discussed, and their function in the learning of adult emotional control was pointed out.

A new problem had appeared, a tendency to cling too closely to the mother. The relationship of this with the fact that the mother had spent a week in hospital, leaving home without warning the child, was brought out. The mother quickly saw that the child had become anxious and agreed that she should be told beforehand when the mother was to be gone. The child was also refusing to take naps. The mother was encouraged to take them with her, since both needed them.

The mother asked for the next interview, when Patsy was two years and nine months old, since she was worried because Patsy turned on the gas stove frequently, saying afterward, "I should be ashamed, huh?" This seemed to happen while the mother was busy in another part of the house. It was suggested that the child was bidding for attention which she might be given by being allowed to help make the beds, and so on, while her mother was doing these chores. The naps still weren't working out, and the mother was advised to put Patsy to bed earlier at night since the total sleep was not enough.

Thus the contacts continued. Patsy was carried through a period of refusing to share her toys, discussed as a problem of her learning the value of things. She went through a normal negativistic period in which she said "no" to everything. The mother was the more tolerant of this episode because she had been warned that it would come and that it is normal, though at its height there was some nagging and the child went through a short period of destructiveness. This ceased when the mother began to include the child in decisions and to give her choices as to *how* things should be done, though avoiding letting her decide *whether* they should be done. The naps finally straightened out.

Patsy destroyed some things by taking them apart in a spirit of investigation. The mother was encouraged to get playthings such as Tinker Toys, which are made to come apart; this was when the child was four, at the last contact, in June, 1946. The child was interested in doing home chores with her mother and each thoroughly enjoyed companionship with the

other. The little girl wanted a new baby, and the mother did, too, but pregnancy was medically inadvisable because of a kidney complication. There were still the occasional temper tantrums of a healthy, uninhibited child.

In all, there have been seven interviews with this mother, extending over three years. The total time spent in the mental-hygiene effort has been approximately three hours.

While it is this larger group of normal parents with normal children that we wish to bring to attention primarily, we have chosen also to illustrate the group in which the child is essentially normal, but the mother distinctly pathological. These cases show that the adult personality pattern is subject to more modification than is usually believed possible.

When eight and a half years old, Joe V. was brought to the clinic by his disturbed and resentful mother, on advice of the school nurse. She complained of his temper, that he used "awful language," was disorderly, and was inattentive in school. She had always been much concerned about constipation. She had never allowed the boy to flush the toilet; she had to examine the stool. He was prophylactically "cleaned out" once a week and was given enemas for "poor movements," for headaches, and for "grouchy moods." Toilet training had begun at three months and continued up to four years. The boy had been afraid of the toilet until he was six and had continued to use a pot until that age.

Delivery had been premature and difficult and development slow. Although Joe has never said what he was afraid of, he always hid his head under the covers when going to sleep.

The father was said to be calm and quiet, while the mother described herself as a "nervous jitterbug." By this she meant that she was obsessed about the need for complete cleanliness and orderliness. She was easily hurt and had little self-confidence. She had grown up in a family of three girls, with a meek, submissive mother and a very strict father. She said that she was "completely ignorant" of sex when married. She had always been frigid.

The patient had a sister, aged three and a half. She was "good" in contrast to his "badness." When they quarreled, he was always blamed and often when both were enjoying some activity, the boy was punished for "picking on" her.

The mother was assured of the boy's normality—that all eight-year-olds are noisy, dirty, and careless to a considerable extent. She was also advised that his intestinal tract would function without enemas, cathartics, and general concern, and that responsibility for this should be his. It was suggested that he also be given increasing responsibility for dressing himself, getting to school on time, and so on. The need for impartiality in treating the children's misbehavior was stressed. The mother was reassured that the case was not at an emergency level of severity as she had feared.

At the second visit, spiteful temper reactions were reported to which the mother had responded with spiteful punishments. She had made Joe write, "I must not be spiteful and mark the rug with my heels," one hundred times. She had had to treat him for writer's cramp after the first fifty. It was suggested that making him clean the rug would have been

more constructive, and the mother said that she had thought of this, but feared he would not do a good enough job. The mother's artistic pride in her immaculate house was discussed with her. The alternate ideal of building sound personality structures in her children was held out to her. She grasped this concept and showed real interest in it.

As time went on, there was steady improvement in mother and child. She became able to disregard his bowel functioning except for occasional casual questions. She now distributed blame for quarrels between the children equally. Nightmares had disappeared, but temper outbursts were still observed. At the most recent visit, the mother reported that she had found a plastic Sacred Heart of Jesus pitted by a bayonet which an uncle had given the boy as a souvenir. Joe admitted having done the deed in an angry moment. Being a sincerely religious Catholic, his mother felt badly about it, but instead of being shocked and punishing Joe severely, she now realized that he needed some outlet for his anger, which she resolved to supply with a dart board. She was able to describe the incident with humor.

The boy now very cheerfully does "K. P." duty after school, preparing vegetables for dinner while he discusses the day's happenings with his mother.

The mother herself feels that she has changed a great deal and says, "I can't tell you what a sick mind I had before. Sometimes I used to think of doing away with myself." Recently she dented a fender on the family car. When her husband yelled at her, she reminded him that he had done the same himself. Only later did she realize that previously she would have been hurt and silent for days after such criticism.

Both parents are planning thoughtfully for the boy's maturity and are pleased as it increases. Joe recently was invited to a girl's house for the evening, but finally brought her to his home instead, because they "could have more fun there." The incident gave the parents much satisfaction.

The boy is now eleven and a half and has been under supervision for three years. Five hours have been expended on the case. There are still some problems present, but the whole family is happier and there has been a fundamental change in the mother's personality and in her attitude toward the boy.

It is important to realize that the mental-hygiene ideal is not the absence of problems, but the capacity to deal with them. This capacity is greater in this family than it was before these five hours of treatment, distributed over three years.

A third case is presented to illustrate that work done with one case as the immediate concern actually affects the whole family constellation.

The G. family is a large one, and while the clinic dealt directly with only two of its members, the whole family, parents and seven children, were affected by the contact.

Roy, the third child, was seen at the mother's request when he was eight years and five months old. The complaints were that he cried easily, and made trouble between the other children, getting them to fight one another. He was doing poorly in school and had asthma. He stole small things in school and from the family, was cruel to small children and to animals, and had a habit of eating plaster, paper, and dirt. There was some masturbation.

The mother was a tired Negro woman of thirty-four, who had severe asthma. She was intelligent and interested in her children. The father was an irritable man when drinking, but when sober, was pleasant and enjoyed his children. The children teased one another a good deal and there were numerous family rivalries.

The problems of the boy were listed and faced with the mother. Most of the things stolen were taken from his mother and his brother next to him in age, who had the reputation of being the family's "good boy" and with whom Roy was continually compared unfavorably. The mother herself was becoming increasingly critical of Roy. We pointed out that the stealing might well be an expression of the boy's resentment. It was suggested that he be given a small allowance and a bank to save some of it in. The importance of giving him suitable responsibilities was stressed, and the desirability of satisfying his need for recognition for any chores performed or consideration shown to others was pointed out to the mother.

We also suggested capitalizing on one of his interests by providing him with scrap wood and simple tools to make things with and encouraging him to bring his friends home to share such projects. In regard to the masturbation, it was advised that constructive activity be suggested to divert him and that he not be sent to bed in the daytime, the mother's usual method of punishment. It was suggested that the mother watch for and prevent the cruelty. The asthma was treated in a pediatric clinic.

Roy was seen again a month later. The mother reported that most of the complaints were still present, but in much less acute form. He had stolen only once—a few pennies from his brother. He had undertaken to feed a neighbor's dog in the owner's absence and had become devoted to it, with no evidence of cruelty. The eating of unsuitable materials had been completely solved when he undertook to prevent his baby sister from this activity. He had also been accepted in a "good" gang of boys whose leader suspended him for a week when he first tried to provoke trouble between other boys; he never tried it again.

The mother's main complaint at this time was that, when he came home from school, he ignored her completely, although he would usually pat the baby affectionately. He would then proceed to rifle the ice box without the mother's permission. She said his ignoring her really hurt her. She would forbid him the food and the ensuing argument would lead to his being punished. She admitted that she had usually felt too busy to talk to him when he came in from school and had recently absent-mindedly put into her pocket a good report card that he had brought her. It was suggested that the mother greet him pleasantly when he came in from school and offer him a snack before he could take it himself, and that she make herself available for his confidences even though she might be occupied with some work at the same time.

Several months went by without a visit because of family crises, but at the next visit much improvement was reported, particularly in Roy's relationship with his father. They had built a small, but sturdy wagon together, and the boy hauled coal, groceries, and ice for the neighbors, earning quite a bit of money and thereby relieving the family finances. He took pride in paying his own way on street cars and buying small necessities for himself. He occasionally borrowed from his mother when short of cash, but was meticulous in paying it back, and had stolen nothing. The mother remarked, "I don't know why I can't think things out by myself like I do here."

Some months later things were still going well, though Roy was a rather poor loser at marbles and got into some fights about it. He led his class in arithmetic. He was close enough to his mother to ask about the male contribution to pregnancy. The mother put him off without discouraging the question and asked advice from the clinic on how to answer it. There have been no asthmatic attacks for over a year.

Treatment in this case extended over fifteen months, but the total time spent in clinic was about three hours. To further both research and therapy, it is planned to see this boy at six-month intervals in the future.

To dissect these cases psychopathologically would have been a time-consuming and a difficult task. In the second case, for instance, it was not necessary to uncover all of the reasons why the mother was overconcerned with the child's bowel movements to realize that her excessive interest was harmful to the boy. It was not necessary to know in detail why it was that she knew so little about boys; it was obvious that she had failed to learn because of suppressions within her own personality. These she was able to overcome to a large degree when advised, using as a lever her emotional concern about the boy. What was necessary was an approach that grasped the possibility of modifying the situation for the better by tackling obvious problems directly, building the helpful and playing down harmful influences of the parent's personality.

Analysis of the mother that would have given her complete insight into her own difficulties would have been complicated and time-consuming. A pattern of action based on respect for her and her interest in her child was effective in changing her own emotional responses and her management of the child. Action in mental hygiene—*i. e.*, seeing a problem and doing something about it—can be effective. After all, we use the serological tests for syphilis even though we don't know their biochemistry.

Parents accept this sort of help gratefully for the most part. Of about 400 such cases now in our files, in only one has there been objection. In that case a neurotic wife complained violently because she feared her history of contraception would not be treated confidentially. Touchy situations are not avoided in the interviews; an effort is made to make questions on parents' sexual adjustment as objective as those about children's difficulties.

Most mothers, whether they have complained about their children or not, are grateful for the interview and frequently

spontaneously say so. Some come back voluntarily to talk over new situations that arise. One Negro girl with a large family came in just after the death of her husband. She had a host of difficulties that were very real. She said that she didn't want advice; that she just wanted the relief that talking things over had given her before. It is a satisfaction when a mother brings in her new baby, saying that she has been helped in handling an older child and wants the same service for this one.

To summarize, the mothers and children attending well-baby clinics present more than the opportunity to maintain physical health. They also present opportunity for increasing the ability to deal with the recurrent emotional stresses and strains incident to living. Such efforts are effective in promoting the happiness and contentment, the "adjustment," of the population, and, since they do this, they are mental hygiene. The technics by which this may be done are not new or unusual, but consist in taking a history, sizing up the patient, and developing a course of coöperative action. There is a requirement that a larger number of items of behavior be admitted as facts to be dealt with medically. Dealing with these facts presents no insurmountable problem to the physician, or, for that matter, to the nurse, with proper medical supervision.

THE OLD ORDER CHANGETH

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PSYCHIATRY, like human nature itself, is a ready and frequent target for criticism. Objections and admonitions are common from within and from without the speciality, from other professions, and from the laity. Often the hope is voiced that the service psychiatry offers may be improved and its responsibilities broadened.

This challenge must stimulate many and varied thoughts in the minds of the many concerned. The psychiatric administrator, the psychotherapist, the clinician, the teacher, the internist and the surgeon, the layman naturally approach the problem differently, each according to his particular bias. The results of their thinking should be a rich harvest, because psychiatry has numerous social and economic as well as medical implications, all of which could be of value if reconciled for constructive use. Regardless of the source of the criticism, the problem that must finally emerge is the same: "Are there valid recommendations to be offered that, put into effect over a reasonable period of time, will bring about improvements in psychiatric practice?"

To approach the more concrete and expedient details of a program calculated to benefit the psychiatric patient, it is well to recognize some of the stumbling blocks that psychiatry has encountered in the past and that should, if possible, be eliminated in the future.

1. Psychiatry has developed out of magic and mystery through philosophy and a more or less abstract psychology to its present position. Unlike other branches of medicine, founded on demonstrable and hence readily understandable structural changes, psychiatry has had no pathology or physiology of its own until recently, and even this acquisition is often based on premises difficult for many to accept.

2. Mental illness, elusive and subtle in its early stages, has not been able to compete with other diseases in practical interest to the student. Paradoxically, in its later, understandable phases—which means when mental illness has reached a frank (but usually custodial) level—psychiatry again lacks popular appeal because of the empirical nature of its therapy, rational therapy always being the physician's chief interest.

To approach the actual problem of improving the treatment of the mental patient, his average present lot must first be examined. When, approximately one hundred and fifty years ago, the humanitarian treatment of the insane was ushered in by Pinel, Tuke, Chiarugi and, later, by Dorothea Dix in our own country, the state-hospital system that developed represented an inestimable gain.

It was not long, however, before it was recognized by those in a position to understand that seldom could more than custodial care be offered to the thousands of inmates in these institutions. True, these unfortunate individuals had come at last to be regarded for what they were—patients. They were no longer punished or neglected in a flagrant way, but passive neglect was often the lot of those who became sufferers even under the new order. Lack of funds was naturally a basic difficulty, but of even more far-reaching importance was the dearth of properly trained personnel and of sufficiently developed methods of diagnosis, understanding, and therapy. No one wanted to hurt the patient, but few were in a position to help him. And while the foregoing picture has been painted as if only of historical interest, it remains unfortunately true even of the present day.

With its pseudo-philosophical orientation and its lack of practical appeal, psychiatry is in constant danger of becoming lost in its own academic fog or strangled because of its fateful sterility. The surgeon, anxious to relieve his patient by a quick incision, and the internist, intent on the earliest possible cure, can hardly be expected to become interested in an intriguing, but profitless discussion of the surgeon's sadism or the patient's personality structure, while an appendix ruptures or a pneumonia grows worse. They will hardly be intrigued by the vagaries of a precocious dementia, emo-

tional and intellectual dilapidation representing a phase far beyond their activity, which is by their definition tuned to the present moment. Psychiatry, vague and abstract on the one hand, descriptive and static on the other, threatens to separate completely from practical medicine.

Despite this problematic background, a way to a solution is clear. Psychiatry must become practical on a theoretically sound foundation; it must be formulated so that it appeals to the student, and it must follow medicine more closely—develop therapies as true as the surgeon's knife and an approach as accurate and as quick. Unless these objectives can be accomplished, the gap between non-psychiatric medical practice and psychiatry, while it may not increase, will hardly become less. It is to psychiatry's best interest that these standards be met.

Straws in the wind suggest such a reorientation. Many psychiatrists themselves have recognized the need. Internists and surgeons, confused when they have encountered problems for which they have no immediate answer, are beginning to concede that psychiatry may supply an answer. A world war, the first, emphasized the importance of diagnosis and selection, although it took a telegram from General Pershing to bring the contribution about. A second world war has given impetus to treatment—in itself a surprising and very important reversal of military policy.

The orientation required in the future would appear to lie in two directions, reaching out as arms from the state hospital to the psychiatric world of to-morrow. The first of these is the *extensive* recognition of psychiatric problems in general medicine by the admission of these patients to general hospitals and the setting up of a psychiatric service in each such institution. Psychosomatic medicine—the understanding of the part played by emotional factors in physical disease and of the rôle of somatic factors in psychological illness—is a natural bridge to this goal.

The establishment of psychiatric out-patient departments and of psychiatric wards in general hospitals is, of course, not without precedent. Massachusetts, among other states, has shown the way. The war has obviously not helped the extension of this approach. However, with the considerably

larger number of trained psychiatrists who will be available, partly on the basis of army preparation, it seems reasonable to expect that the trend toward the incorporation of the psychiatric point of view in the general hospital will gain in the post-war era. That the enormous burden of psychiatric illness that the war has created will demand such a reorientation need scarcely be pointed out.

Psychiatry sorely needs support from medicine to accomplish this reorientation. Instead of the historical coolness the general hospital has shown toward psychiatry, evidenced in obvious reluctance to open psychiatric wards or to accord the psychiatrist a position of importance on the staff, a warmer feeling and a spirit of coöperation must be developed. Psychiatric opinions are apt to be rejected as impractical and useless—and they often are just that. But would it not be better for the internist to indicate what he wants, how he can use the consultant's advice, allowing for modification, instead of disregarding the whole matter without explanation or reasonable effort to reach an understanding? Where mutual tolerance has been tried, it has proved its value. The psychiatrist who has to face practical problems in the light of the internist's or the surgeon's needs gradually achieves the proper level.

The second direction is toward the establishment of psychiatric institutes in which *intensive* study of the patient from all aspects is possible and in which the emphasis is placed on teaching and research. By "all aspects" is meant not only the usual psychiatric and psychological techniques, but the various facilities of medicine in general, of nursing, and of social work. Such an approach permits the development of teaching and research facilities. Research itself leads to what is psychiatry's greatest need—namely, preventive methods. That there is a strong trend in the direction of such institutes is shown by the number of states that already have them—New York, Pennsylvania, and California among others—and those that expect to build them—Virginia, Maryland, and Ohio.

The usual dilemma presented by the psychiatric patient is well known. The case is ordinarily of long standing and well crystallized before it comes to the attention of those who

might give help. For that reason, at the very outset discouragement is apt to prevail. The illness, having developed insidiously over a long period, is so deeply entrenched that it seems almost impossible to do much constructively. Even if the root of the problem could be reached, the amount of time and energy involved in treatment might well represent more than could be expended under normal circumstances or than would be defensible from the social standpoint. To justify the expense, something beyond the individual case is practically demanded; that something is research. In other words, theoretical interest in the case may make worth while the costliness of individual treatment.

Obviously, the combination of treatment and research thus envisaged can best be carried out in some type of psychiatric institute, where the possibilities for subjecting the case to coöperative study by psychiatrists and others naturally exist. In such institutes usually the expense involved is partly, at least, defrayed from public funds; and in terms of preventive psychiatry and in relation to the education of specialists, treatment so undertaken becomes practicable.

It is not unlikely that one outcome of the coöperative approach to problems of mental disorders in the psychiatric institute will be a liberalization of attitude toward personnel considered competent to treat. The psychiatric social worker has already come far in the development of techniques of a therapeutic kind that supplement those brought to bear by the psychiatrist. Treatment of relatives as well as of the patient himself has particularly been emphasized in this approach. The psychologist, by participating especially in work with children and by undertaking correctional treatment in cases of special disabilities as well as in instances of emotional disorders (where play technique, for example, is appropriate), has also begun to share in psychotherapy. The non-directive method expounded of late bids fair to extend this new source of aid.

The part that the occupational therapist can play has been given added and distinct prominence during the war; and more recently the parts contributed by the nurse trained in psychiatric methods and even by the librarian in a mental hospital have come to the fore. In a field in which treatment

is so time-consuming and the shortage of professional personnel is such an obvious handicap, any liberalization in attitude calculated to bring about the coöperation of properly trained individuals from whatever calling must be regarded as a most hopeful sign.

The trend of the times seems distinctly in line with the sketch here presented. It might, in fact, almost be said that the above picture does little more than show what is already plainly written on the wall. The state hospital has played its highly significant part as a step beyond the inhumanitarian treatment of the mentally ill, but the weaknesses of that system are now apparent and demand a new forward step if proper care of mental patients is to be achieved. The era that lies ahead will represent, on the one hand, emphasis upon the early recognition of mental illness in the general hospital where it is apt to be seen first. By an infusion of the psychiatric point of view in practical form into medical education, the general practitioner will be enabled to contribute significantly to the timely recognition of mental disease which, if neglected, may well become hopeless.

The psychiatric institute represents the other complement to the state hospital. Research carried out hand in hand with the treatment of specially selected cases, with the aim of revealing basic factors in the illness so that prevention will be possible later, and education of various specialists in the setting of such an institution are the objectives to be sought from this intensive approach.

Needless to say, the state hospital will not become by any means superfluous after these new developments have matured. Instead, it may well be revivified. No longer will an air of hopelessness prevail in its corridors, since constant circulation between it and the general hospital as well as the psychiatric institute will create a dynamic interplay in which each of the three institutions will have an active share.

The establishment of psychiatric institutes and the provision for psychiatric research generally must proceed on a hitherto unprecedented scale if results commensurate with the immensity of the social problems involved are to be achieved. Now that research has been overwhelmingly

demonstrated by industry itself as a paying proposition, and now that it is recognized with ever-increasing clarity that the very survival of civilized society depends upon rapid and comprehensive advances in the psychological and social sciences, it is time to take a lesson from nature as to the scale of operations required. In the struggle for existence in which destructive forces are constantly at play, the survival of any species is predicated upon a lavish, an almost profligate investment that every spawning of a fish or ejaculation of a human male attests. Only upon a similar pattern of superabundance can the healing capacities of psychiatric resources be actualized: so much money, so much of every material means and moral support must be thrown into the balance on the constructive side of the present struggle for civilized existence that despite every gain for destruction released by advances in physical science, the balance will be tipped against death in favor of life.

In practice, such a policy would mean that appropriations from public funds or private philanthropies must be made in terms not of thousands, but of millions and even billions of dollars; and an awakened public opinion would need to throw its entire weight in support of such educational and therapeutic practices as must go hand in hand with the research to be undertaken. Let there, then, be failure on this front or on that; resources would still be available for pushing on by other roads and by other vehicles, till success at whatever cost, short of civilization itself, is achieved.

TRUANCY IN CHILDREN REFERRED TO A CLINIC

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AN increase in the number of cases of truancy has been observed of late in our clinic. Because of the frequency with which this was noted, it was thought advisable to give closer study to the problem, so that any findings of value might be utilized in the community.[1]

A typical clinic year—1944-45—was selected, during which time 98 cases were seen. The chief reasons for referring these children to the clinic, listed in order of frequency, were as follows:

Truancy	21
Stealing	13
Incorrigibility	8
Albers-Schömberg Disease	8
Sex misdemeanors	7
Low mentality	5
Epilepsy	5
Late hours	5
Running away from home	4
Enuresis	4
Lying	4
Temper tantrums	2
Speech disorders	2
Inferior clothing	2
Headache (psychogenic)	2
Timidity	1
Eating hair	1
Retarded growth	1
Gambling	1
Congenital syphilis	1
Spells of faintness	1

There were few instances, however, in which, after careful study, one disorder alone was noted. While truancy was admitted as the chief complaint disorder in 21 cases, in an additional 33 a history of truancy was also noted among the complaints. The most frequent combinations were: (1) tru-

[1]Funds for this study were supplied by Mr. E. I. Kaufmann, Washington, D. C.

ancy and stealing; (2) truancy and low mentality; (3) truancy, incorrigibility, and stealing; (4) truancy and running away from home; and (5) truancy and late hours.

A study of the referring agencies was significant. Of the 98 cases for the year in question, only 31 were referred by the parents. All others were referred by social agencies or schools. In most of these cases, however, we received the utmost coöperation from the parents.

In the evaluation of these cases, there were certain factors that seemed to favor truancy. Listed in order of frequency, these were: (1) poor parental control; (2) no goal; (3) gangs; (4) pushed against a low I. Q.; (5) low economic status, with desire to keep up with others as to styles and dress; (6) inability to keep up with the progress of the class after a severe illness; (7) punishing parents; and (8) dislike of teacher.

1. Poor parental control was exemplified in two types of case:

In the first group the parents were poor disciplinarians. If their children decided against going to school, these parents seemed powerless to require them to do so. In some instances these youngsters would feign illness; in others they simply decided against going to school. Threats of punishment would leave them unperturbed, largely because they knew from past experience that their parents never did carry these out, and in some instances even tried to protect them against the school authorities.

In the second group, the occupation of the parents was a significant factor. Usually both parents had to work and would return home in the evening often too late and too tired to check up on the day's activities of the youngsters. These children, realizing that no check was being made of their activities, took advantage of the situation and failed to go to school. This latter group was much the larger of the two. Neither group showed evidence of proper family-life relationship, the importance of which was stressed by C. P. Taft in his study of juvenile delinquency.[1]

2. Next in size was the group of cases with no goal in view. The parents of such children often had had a limited educa-

[1]See "To Attack Juvenile Delinquency: A Seven-point Program," by Charles P. Taft. *Journal of Social Hygiene*, Vol. 29, pp. 485-91, November, 1943.

tion. Nevertheless they were managing to get along and in many instances lived comfortably and seemed contented. A job, a good suit, and a good time seemed to be all that was necessary. For such youngsters to be able to read and write was considered enough, as they expected little from life and saw no need for any further education for what they expected to do. Often the histories of these cases would show that these children had been very ambitious, but as they grew older, parental indifference and the lack of any motivating force had caused them to surrender to the environment. One youngster quoted his father to the effect: "Only fools waste their time in school. I can make as much money as anybody."

In this connection one recalls the statement of Carleton Washburn: "The school must provide for diagnosis and treatment of children whose lives are not satisfying to themselves or their fellows. It must attempt to orient its whole organization toward the fulfilling of every child's needs for security, for self-expression, and for social living."[1]

3. "The gang" was a significant factor in a large number of cases. Youngsters ordinarily docile, quiet, well-mannered, often assumed heights of bravado or braggadocio in gangs. The larger boys who turned to truancy were usually idolized by the smaller ones and hailed as leaders, largely because of their thrilling stories and at times their daring. As a result, the smaller youngsters followed the larger boys around instead of attending school. It was noted that in such cases the parents were not held in high esteem and the home lacked the necessary leadership, which, therefore, was sought elsewhere among the larger boys. In some instances the obedience and loyalty demanded and received from the gang leaders were much greater than those accorded the parents. In other cases parental love was not inspiring, and was regarded by these youngsters as an evidence of weakness.

Huschka[2] has expressed the belief that parents may show too much love or too much hostility to their children, and has stressed the necessity for improved mother-child relationship.

[1] See "The Educator's Response," by Carleton Washburne in the symposium, "The Challenge of Childhood." MENTAL HYGIENE, Vol. 19, pp. 47-58, January, 1935.

[2] See "Pathological Disorders in the Mother," by Mabel Huschka. *Journal of Nervous and Mental Disease*, Vol. 94, pp. 76-83, July, 1941.

Adequate substitutes for the gang, such as the Boy Scouts or a boys' club, or stress on group activity have also been suggested to meet this situation.[1]

4. In spite of a low I. Q., parents often mapped out an ambitious program for their child, and then were prone to blame the teachers for the child's poor showing. These youngsters, pushed on one side by their parents and on the other by their teachers, soon got the feeling they were being pushed "against the wall" and made attempts to extricate themselves, becoming aggressive, irascible, and incorrigible, and finally taking to truancy. In this situation, the atypical school offers a partial solution. Attempts should be made to determine the particular skills and habits of such youngsters, so as to help them to find some source of immediate security and a means of making a livelihood later in life. Glueck[2] has rightfully stressed the need for constant readjustment of the school curriculum to meet the specialized needs of such individuals, if they are to continue to live in the same environment.

5. "Keeping up with the Jones'," to use an old phrase, was found to play a great rôle in truancy. This feeling caused much friction in classrooms where many youngsters developed feelings of inferiority. Comparing their clothing with that of others, or having their attention drawn to it by children whose parents were better able to provide for them, caused these youngsters to get the feeling that they "did not belong." The result was that they refused to go to school unless parental influence and stress on education were strong enough to counteract this feeling.

6. After a period of illness many parents, in order that their youngsters might not fall behind their classmates and be considered dull, sent them back to school before they were fully recovered. Such youngsters were physically unable to stay in school all day and to carry the regular school load. Usually they resorted to malingering in order to stay at home so as to permit full recovery, or else, when forcibly sent to school, refused to go into the classroom. The work of Blumenthal, too, has shown how a physical defect, coming at a par-

[1]See *Behavior Problems of School Children.* New York: The National Committee for Mental Hygiene, 1946.

[2]See "Mental Retardation and Juvenile Delinquency," by Eleanor T. Glueck. MENTAL HYGIENE, Vol. 19, pp. 549-72, October, 1935.

ticular time, may be an important factor in juvenile delinquency.[1]

7. Some youngsters got the notion that they were going to school to satisfy the desire of their parents. Consequently, if any unpleasant parent-child relationship developed, the children looked upon staying away from school as a means of punishing the parents.

8. Dislike of the teacher was the least frequent cause of truancy. In a few instances it was noted as a projection mechanism. The parents might inadvertently or carelessly make uncomplimentary remarks about the teacher that were overheard. The child would go to school and at the slightest provocation become impudent. The teacher, taken off guard, would resort to punishment instead of seeking the cause of this overt behaviour. This reaction, however, would only serve to substantiate the prejudice that the child had subconsciously or consciously built up against the teacher. As a result, he would stay away from school.

It is the opinion of Henderson and Gillespie[2] that such a reaction reflects unhappiness in the home of the child. The importance of the attitude of the teacher was ably expressed by Wickman,[3] while others have shown that shaming and ridiculing before the class may produce untoward results.[4]

While the number of cases reported here does not permit definite conclusions, certain observations were noted. These were:

1. There was a need for improvement in the general cultural pattern in most of the neighborhoods from which the children came.

2. Closer parent-teacher association was necessary to acquaint parents with the growing needs for better education, and teachers with the problems many parents had in trying to keep their youngsters in school.

[1] See "Physical Defects in the Genesis of Juvenile Delinquency," by F. Blumenthal. *New York State Journal of Medicine*, Vol. 41, pp. 1749-57, September, 1940.

[2] See *Textbook of Psychiatry for Students and Practitioners of Medicine*, by D. K. Henderson and R. D. Gillespie. Fifth edition. New York: The Commonwealth Fund, 1940. Chapter 18.

[3] See *Teachers and Behavior Problems*. by E. K. Wickman, New York: The Commonwealth Fund, 1938.

[4] See *Behavior Problems of School Children*, already cited.

3. The classroom should be considered as a workshop, a place where the pupils come to work, and this should be kept uppermost in mind.

4. When punishment becomes necessary, it should be individualized and made as constructive as possible.

5. The stressing of differences of whatever form should be avoided in the classroom, since there is always the possibility that it may cause embarrassment to some pupils.

6. The emphasis should be on cleanliness, in which all may compete on equal terms, and not on form of dress.

Finally the pertinent statement by Wile—"The child must be freed from all that would tend to destroy it, and rob it of its fruition of maturity"[1]—should be considered as the guiding principle in the proper approach to this problem. This advice cannot be too strongly stressed in our communal life.

[1]See his paper, "The Challenge," in the symposium "The Challenge of Childhood." MENTAL HYGIENE, Vol. 19, pp. 38-46, January, 1935.

BOOK REVIEWS

THE PHILOSOPHY OF INSANITY. By a Late Inmate of the Glasgow Royal Asylum for Lunatics at Gartnavel, with an Introduction by Frieda Fromm-Reichmann, M.D. New York: Greenberg, Publishers, 1947. 116 p.

The author of this small volume was an inmate of a lunatic asylum in Glasgow, Scotland, during the middle of the last century. Out of a fervor to acquaint the public with the nature of mental disease and its curability, the anonymous author set down his feelings and experiences as a patient and observer. Being a man of intellect and of deep human feelings, the author discussed not only the dramatic cases he has seen, but his ideas about etiology, comments about treatment, notations about prevention, and general philosophical remarks regarding insanity.

As Dr. Frieda Fromm-Reichmann, who made this "find," states in her introduction, the writer was a man of unusually keen perception; he anticipated the spirit of modern psychiatry by pointing to the similarity between the mentally well and the mentally disturbed as far as basic emotional dynamics are concerned. Dr. Fromm-Reichmann calls this a "precious little book" and it is just that. The intensity of the author's interest, the romantic, slightly hyperbolic flavor of the writing, and the vigorous defense of the "moral" care of mental cases, make fascinating reading.

The republication of the volume at this time has definite mental-hygiene implications. Although *The Philosophy of Insanity* is not as compelling as Clifford Beers's book, it still should be an accepted classic in the field of mental hygiene. The author's praise of Dr. Mackintosh, Head of the Gartnavel Royal Lunatic Asylum, indicates that the conflict between humanitarian treatment of lunatics and treatment by neglect was still active at the time he wrote (1860). In several well-reported cases, the writer shows how kindness, sympathy, and, above all, understanding relieved many of the lunatics in an excited state.

An interesting sidelight is developed in the author's discussion of the relationship between the spirit of freedom of the people of Great Britain and the use of humanitarian methods. In the author's eloquent language (p. 67): "Freedom is our own country's peculiar boast. Freedom to her people—freedom to the slave—freedom to the lunatic to the very uttermost bound, consistent with the safety of himself and those around him."

His account of the basis of insanity, the development of delusions and hallucinations, and the bad mental effect of bodily and mental excesses is so honestly viewed and earnestly phrased that the modern reader forgets some of the now disproven statements—*e.g.*, those about phrenology.

The author presents tables showing the causes of insanity of cases admitted to the asylum during 1859. It is interesting to see with what acuteness emotional problems of patients were viewed. One table, for example, lists among other causes of insanity, anxiety, chagrin, disappointed love, remorse, and so on; even "reading works of fancy" is included in the list of etiologies.

Not only does the author discuss cases, treatment, and prognosis, but he also has much to say about prevention. He inveighs against the use of narcotics and of tobacco, fanaticism, religious intolerance, and so forth.

The volume has its share of Victorian morality and literary furbelows, yet it makes a fascinating bit of psychiatric history. It should interest not only those in the field of psychiatry, but the general public of our modern and sometimes smug era.

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EMOTIONAL PROBLEMS OF LIVING. By O. Spurgeon English, M.D. and Gerald H. J. Pearson, M.D. New York: W. W. Norton and Company, 1945. 438 p.

In the field of prevention and treatment of personality maladjustments, it is at the present time a generally accepted fact that the development of these maladjustments is most intimately associated with experiences during the early stages of growth and maturation of the individual. Since the best chance of developing a successful program of preventive psychiatry depends upon how well we can reach those who are most intimately associated with the developing child, it follows that most of our efforts should be directed toward acquainting such persons with the possibilities during the development of the child that may lead to maladjustments. It is, therefore, highly desirable to have clear presentations of the problem systematically built up around the development of the child and presented in a way that the layman or the student can understand.

This is just what the authors have attempted to do in the present book, and in the opinion of the reviewer, they have succeeded in doing so in a very satisfactory manner.

The basic theme that runs through the whole volume is the proposition that personality maladjustments are largely due to conditions

that interfere with the proper course of development through the various stages of maturation. The disturbance may be directly due to traumata or fixations occurring at any one of these stages and causing a maladjustment at that time, or the foundation of such a disturbance may be laid at any one of these stages and then be brought to the surface later on by a suitable precipitating factor.

In keeping with this idea, the authors—after a brief introduction in which they discuss the general nature of adjustment, the conflicts that may interfere with it, and the main issues that lead to such conflicts—proceed with a systematic presentation of the various major phases of personality development, emphasizing particularly the critical points occurring during these. Each of these phases is discussed in terms of the conditions that are essential for proper development and the factors that may have an adverse influence on it. This is followed by a description of the more commonly occurring types of maladjustment that develop under adverse conditions, and finally by a discussion of prevention and treatment.

The theory of personality development followed by the authors is the one advanced by psychoanalysis. The phases discussed in the book, therefore, are the oral, the anal, the phallic, and the latent. The Freudian concept is logically developed and adhered to, particularly in these four early stages. After this, the authors proceed with the more conventional sequence of puberty, adolescence, marriage, maturity, involution, and old age. In the discussion of the latter, although psychoanalytic mechanisms are in the foreground, other concepts are added—psychological, sociological, and biological.

In the present review no attempt can be made to summarize all of the material that is presented in each one of the chapters. A few comments, however, are indicated here. It is obvious that, to deal with this subject comprehensively, one would need much more space than is available in the present volume. The authors, therefore, had to restrict themselves in certain parts of the subject and consequently the various chapters are not all of equal thoroughness and comprehensiveness.

The stages treated most adequately are the ones up to and including puberty, and it is fortunate that this is so, since, after all, for treatment and particularly preventive work in this field, those are the most important stages of development. As we come into the field of adolescence and the later periods, the material is treated somewhat more superficially.

Since the book is addressed primarily to laymen and students, it is quite understandable that the neuroses and character disorders are given more emphasis than the psychoses. Furthermore, treatment is presented less systematically than prevention, and finally the broader

sociological implications do not receive as much attention as the narrower confines of the home and the immediate family. Some readers may also feel that not enough emphasis is placed on organic factors as they affect the individual both in his normal development and in the causation of personality maladjustment.

All the points mentioned in the last paragraph do not essentially detract from the value of the book. The material is organized systematically and written in a most adequate and stimulating style. Although it is addressed to the general public, it does not sacrifice exactness and actual facts for the purpose of making a good presentation. There is ample illustration of various points by brief, but clearly outlined sketches of cases. Interspersed throughout the book are bits of good, wholesome advice and warnings of danger points.

The book should receive wide reading, particularly by the general public, but it is also most admirably suited for the teaching of students in psychology, in social work, and, especially, in undergraduate medicine.

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PSYCHIATRY TO-DAY AND TO-MORROW. By S. Z. Orgel, M.D. New York: International Universities press, 1946. 514 p.

This comprehensive textbook of psychiatry covers the history of psychiatry, the normal development of the individual as expounded by the Freudians, symptoms of disease, disease classifications, and the principal symptomatology and treatment, including the nursing care, of all the sub-items in the American Psychiatric Association's classification of mental diseases. Furthermore, there is a chapter on war problems, occupational therapy, social work, and the legal aspects of insanity, including commitment laws. This book contains a vast amount of material carefully collected and is full of helpful hints in the treatment of conditions of all sorts.

I see little point in devoting specific chapters to dementia paralytica, cerebral syphilis, and psychoses with epidemic encephalitis, and it would seem to be a compromise enforced by the official A.P.A. spstem of classification. The Freudian doctrines are well expounded, and the presentation of the material is quite clear.

In general, this is a rather helpful text, with short references to all the latest treatments without the details that are best presented in special monographs (for example, insulin treatment, electroshock, and so on). Curiously, in the chapter on commitment laws, I find no statement whatever concerning the commitment situation in Mary-

land, which probably has the easiest and most useful commitment procedure in the United States. This is an item that should be corrected in future revisions of the book.

A glossary of terms and a thoroughgoing index complete this useful volume.

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THE PERSON IN THE BODY; AN INTRODUCTION TO PSYCHOSOMATIC MEDICINE. By Leland E. Hinsie, M.D. New York: W. W. Norton and Company, 1945. 263 p.

This book was written to serve as an introduction to psychosomatic medicine for the patient and for the general physician. It is a convenient size for handling and the type and format make for ease and rapidity of reading.

The fact that the book is addressed to such a large reading public results in some discrepancies of audience focus. Material presented in one part for patient consumption is indicated as not being desirable for the patient in another section. This ambivalence of direction is evident throughout the book. The major portions appear to have been written primarily for the general physician in an effort to aid him in the treatment of psychosomatic problems in their incipiency, and before neglect of the "person in the body" leads to more serious psychiatric difficulties. Lay readers, however, could profitably read the book for an understanding of the fact that mental illness can influence physical illness and that physical illness can be induced by mental illness. The many interesting case reports well illustrate the interdependence of mind and body both to the professional and to the non-professional reader. Psychiatric terms are clearly, simply, and interestingly defined and illustrated.

Interspersed throughout the book are some excellent principles of mental hygiene, which the reviewer would like to have seen organized and expanded into a separate chapter. "Prevent the child from adapting himself to invalidism by encouraging the emotions in healthy, adult directions. Prevent the parents from abetting debility in the child in order that they may always maintain the child as a child, or in order that they may perpetuate their own neurasthenic childhood through their children." Prophylactic measures for correcting the faulty type of thinking indicated by the projection mechanism in puberty in an individual with schizoid traits are indicated, and emphasis is laid upon the importance of being certain that the facts of reality are correctly understood by the emotionally immature schizoid individual. "Naïve and fantastic concepts of himself and of the people about him" must be cured. The

author summarizes: "Get the schizoid person first to affiliate his emotions with group activity, to share in some common aim—scholastic, recreational, religious, or professional. Externalize his emotions first through relatively impersonal pursuits. He will begin to feel at ease; he will begin to establish confidence in himself when he experiences the pleasure of giving some freedom to his emotions. It is like 'blowing off steam'; internal pressure, felt so keenly in the body of the schizoid, is appreciably reduced when the emotions are set free upon social groups."

The style and content of the book are illustrated by the following passage:

> "As extravagant as nature is, she nevertheless makes provision for psychological economy. Indeed she stores up the bulk of psychological experiences, catalogues them, and puts them on the shelf, available when necessary. Since the majority of activities of the infantile period are well endowed with emotions, they are carefully preserved, even though as such they are inappropriate for later use. . . . The little child may learn that the most effective way to conquer the gigantic mother or father is to throw a tantrum. Literally, tantrum means tension and refers to the infiltration of muscles with emotions. The tantrum is a pristine manifestation of psychosomatics. It is often a highly effective, though later a morbid, type of response. Many psychosomatic problems in medicine are little more than tantrums modified slightly to remove the stigma of infantility."

Jung's concept of the collective unconscious appears evident in the following:

> "Nature is man's most prolific collector and hoarder. She collects, retains, and uses a variety of antiques, handed down from past ages. They constitute the instinctual reactions. Ordinarily we feel their urges although we do not recognize them as concrete drives of the past. The heritage of eons makes itself known conceptually through dreams that reproduce primitive methods of the mind. . . . Nature is selective in what she preserves, stressing particularly the conservation of experiences emotionally connected with people. Experiences with human beings are the key-note of living."

The author gives an excellent brief series of generalizations for the evaluation, by the general physician or the psychiatrist, of patients with psychosomatic disorders originating in the mind and expressed as "physical complaints, not physical signs."

> "The greater the number of complaints in the absence of organic signs, the more likely it is that the trouble stems from the mind."

> "The longer the complaint has lasted, in the absence of data supporting an organic disease, the more probable it is that the source of the ailment is mental."

"It is common to get a history of the same or similar complaints as of years ago."

"The psychosomatic symptom complex often appears at irregular intervals, usually during periods that are stressful to the patient."

"Many, but not all, psychosomatic patients do not wish to be interrogated for the smaller details of their symptoms."

"Not a few patients insist on repeating the same symptom over and over again. Repetition gains the same end as paucity of information does."

"Some psychosomatic patients show almost a compulsive urge to engage the attention of the physician, though they have nothing new to say about their physical symptoms."

"Some psychosomatic patients, while recounting their physical complaints, interpose little 'asides' that seem not to belong naturally to the general topic under discussion. Often these 'asides' contain the kernel of the mental trouble that is curtained by the physical complaint."

"When psychosomatic symptoms first appear around middle life in a person who has up until that time adjusted himself reasonably well and without abnormal reactions to life situations, it is highly probable that there is an accompanying physical disorder of a more or less primary nature."

An important point for the general physician is made by the author in the statement:

"But when [the mind] overstimulates an organ in the guise of a psychosomatic syndrome, it can very conveniently do so when that organ is already pathological due to causes not at all connected with the mind. In other words, the mind may and often does superimpose its own kind of sickness upon an already diseased organ."

Some harmful negativistic lay approaches to problems of mental illness are stressed. "It is futile to tell a full-fledged patient to take his mind off his body and put it on work or play. It is an old-fashioned and ineffectual idea to recommend a vacation in the interest of a psychosomatic illness. Vacations do not vacate a physical complaint of mental origin. The advice, 'forget about it,' is even more useless." The author's negativism toward hypnosis for use by the general physician is understandable.

By way of summary, the author indicates that he advocates two methods of approach to psychosomatic ailments. The first he describes as the "uncovering" form of mental therapy. "It consists of a direct and active interest in the symptoms; it means that the symptoms are traced back to their origin in the mind of the patient, from which point their many ramifications into the life history of the patient are completely studied and treated. By this method the disturbing emotions are handled directly and the con-

nection between the subversive use of the emotions and the organs of the body are clearly established. The truth, intellectual and emotional, sets the patient free." The second method of psychotherapy is called the "covering-up" method. "By this type of handling of a psychosomatic illness, attempts at adjustment to the environment are emphasized. It is the hope of the patient and the physician that if the patient can establish connections with the personal and impersonal environment, the emotions may be drawn from the organs of the body to the external issues about him."

The book should be of most value to physicians, who are not specializing in the treatment of mental illness, but who desire some knowledge of a rational basis for the treatment and understanding of their many patients with psychosomatic complaints.

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Psychiatry for Social Workers. By Lawson Lowrey, M.D. New York: Columbia University Press, 1946. 337 p.

Dr. Lowrey's book is comprehensive in its field. It is simplified for lay reading, with parenthetical definition of the more technical terminology. The author has enabled the reader to become a participating diagnostician rather than merely an observer of the processes. Interpretative and illustrative statistical data are used as a means rather than made an end, and are not cumbersome, as is so frequently the case in professional treatises.

In his introduction the author sets forth the social implication of public health, and the development of hospital care for mental diseases. Then follow three chapters on the data of psychiatry, historical and diagnostic; etiological factors; and clinical combinations of symptoms. There are seven chapters on the psychoses of standard classification, one on mental deficiency, one on psychopathic personality, and two on behavior disorders (the first on those due to internal pathology and the second on reactive behavior problems). The final chapter deals with problems of rejectees and veterans.

Arthur W. James.

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Counseling Methods for Personnel Workers. By Annette Garrett. New York: Family Welfare Association of America, 1945. 187 p.

This book contains much practical information and many helpful suggestions for alert counselors in industry. It is a matter of regret that it was not available during the war years when, under the pres-

sure of war contracts in areas of man-power shortage, employers were frantic over problems of efficiency arising from conditions that frequently had little or nothing to do with plant organization. In desperation some threatened to hire family case-workers or to train industrial nurses to give family counseling. Even though the company had contributed for years to the support of community welfare agencies, the officials evidently did not know how to make practical use of such services.

Had a sufficient number of trained workers, qualified by personality organization as well as broad experience, been available, it would have been wasteful, then as now, for industrial concerns to attempt to duplicate within the plant the services community welfare agencies offer. The author shows, through illustration and discussion, that men and women and their families at times are in need of counseling, whether employed by large or by small concerns. The intelligent worker in serious trouble is frequently unwilling to seek help for personal problems from those connected with his means of livelihood for fear of jeopardizing his job. The man or woman on the line may be willing to discuss minor problems and to ask for sources of assistance or advice. Beyond a certain point it is well for any employee to obtain counsel from an agency outside the plant.

While industrial counseling requires a considerable body of knowledge about human personality and behavior, the author states that proficiency is within the grasp of those who are willing to study and to remain sensitive to the problems of others. She recognizes that giving advice by employer to employee or *vice versa* has always been a practice in the past. Much of this was wise, friendly counsel based on long-standing acquaintanceship. Sometimes recommendations based on snap judgment rather than on understanding, or accompanied by a happy combination of circumstances, have attained success. Failures tended to be overlooked or attributed to the willfulness of the recipient. Again, counselors with a peculiar sensitivity to human needs have been notably successful even though they have not recognized the principles or methods whereby they work.

Part I of the book is entitled *Counseling and Human Behavior*. The author stresses the effect of the counselor's personal attitudes upon his procedures and upon others. She devotes some space to what are perhaps the most irritating forms of behavior that appear on the job—unreasonableness and indecisiveness. The personal histories, many of them of women, present a variety of problems based largely on conditions outside the plant, which the counselor must face.

There is frank recognition of the need that the counselor have the specific job of counseling, without power to hire or fire and without

any other supervisory activity. The necessity that the individual employee be free to take or to leave the counsel without fear of reprisal, is clearly and repeatedly brought out.

Part II treats of basic methods in counseling. Kindly interest, ability to listen respectfully, keenness of observation of incidental factors, and skilled questioning are qualities that make for good interviewers. Through illustration and precept, the writer shows the meaning of understanding from the point of view of the worker in terms of *his* experience rather than in those of the counselor's background.

Part III gives an account of specific counseling problems connected with the initial employment, the separation of the employee from the job, adjustments within and without the plant, and coöperation with the immediate supervisor as well as agencies connected with the company or outside of it. In this section as in the others, a great deal of illustrative case history is used. While the examples are drawn predominately from women workers, it should be understood that this apparently greater number of difficulties is probably rather a function of war-time employment than a sex difference.

Whether the interview has to do with becoming acquainted or with leaving employment, getting along with workers on the line, or the influence of outside difficulties, attitudes must be rebuilt and motives changed. Any prolonged period of retraining or of reorganization of personality is likely to be beyond the reach of a counselor employed by the company. The value of knowing community resources, both individual and group, is shown repeatedly in the personal histories.

There are many intimate problems that the employee may expose inadvertently in discussion or disclose reluctantly through too rigorous questioning. The employee's fears are then likely to result in resentment against the counselor whom he holds responsible for the disclosure. Such antagonism is often communicated to other workers not connected with the immediate problem. There is a tendency for the group then to array themselves in opposition to the counseling services and the constructive influence of the counselor is lost.

Possibly the keenest portion of the book treats of the relationships of the counselor and the foreman. The author frankly recognizes the necessity for a type of helpfulness that does not threaten the importance of the foreman with his workers. She does not go into the matter of foreman training of a more formal and psychological nature. Apparently the immediate supervisors are to pick up understanding incidental to contacts with the counselor and with the employee. It is evident that the daily behavior of the foreman toward

his employee is quite as important to the success of the counselor as the latter's attitude toward the foreman, who carries the responsibility for production and morale in his department.

The fourth portion of the book deals with case-work and counseling. The author frankly presents histories which indicate much more helpfully than do protestations of superior skill why industrial counselors may not often enter successfully into so professional a field. The skill as well as the time required is usually not at the disposal of the industrial counselor.

It is safe to hazard a guess that counseling will not be a war casualty. Personnel work will, we hope, shortly attain the professional recognition it deserves. Industrial relations departments will then assign the keenest, most sensitive member of the staff to the important job of counseling.

Coöperative relationships will develop much more rapidly if boards and trained staffs of welfare services outside of individual industries awaken at once to their opportunity. The problems of men and women are very much the same whether at work or in the home or in the community. The setting differs and is sometimes confusing chiefly because of its individual complications. If, however, private enterprise is to continue, it will do so because men and women have learned to live together much more sensitively and effectively than in the past. *Counseling Methods for Personnel Workers* is a distinctly practical contribution in this direction.

ESTHER H. DE WEERDT.

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PUBLIC MEDICAL CARE—PRINCIPLES AND PROBLEMS. By Franz Goldmann, M.D. New York: Columbia University Press, 1945. 226 p.

This book gives, in encyclopedic, but highly condensed and readable form, the story of "the progress of public policy from the time of the emergence of community responsibility for medical care up to the turning point of the global war." That this progress has not been achieved overnight and is still in the making, is evidenced by the author's comments that "some beginning has been made to bring the public services for the sick into closer relation with the public provisions for the prevention of illness and promotion of good health and to coördinate them with nongovernmental activities. But the development has been fragmentary and far from uniform. Some of the policies and procedures adopted long ago have proved to possess a surprising longevity. They have remained substantially unchanged or have been but slightly modified—in spite of the rapid advance of

scientific medicine and the profound social and economic changes that have taken place."

The author himself has very neatly summarized the contents of the book, which he declares deals with public medical care as a social movement. It is in two parts. The first part attempts to analyze, interpret, and appraise public policy in providing, at public expense, facilities and services for the care of the sick; to follow those currents of thought which have left a deep mark; to find the common elements in the vast number of developments that have taken place when enthusiasm crystallized into programs; and to trace the guiding principles of organization and administration that have emerged in the process of a piecemeal and, often, haphazard growth.

The second part takes up the problem of planning for clinics, hospitals, and related facilities; for organization of professional services; for payment; and for administration of medical care. It endeavors to show the relative merits of the method of taxation and its potential value to the development of broad programs of health and social security in the future, when the realization of freedom from want will tax the ingenuity of all democratic countries.

Readers of MENTAL HYGIENE will of course be especially interested in the references to the developments in the public aspects of the mental-hygiene movement, succinctly described by Dr. Goldmann as follows:

> "Four conspicuous developments mark the line of progress. Highly specialized facilities have been developed for several types of mental deviation. Institutions for the mentally sick have been transformed into hospitals in fact as well as in name. Public responsibility has been accepted for the establishment of necessary facilities and the regulation of nongovernmental activities in this field. The services of governmental hospitals have been made available to everybody regardless of economic considerations."

The author feels, however, that the advance, greatly varying in rate and speed, has been one of kind rather than of degree.

> "Newer scientific concepts penetrated the cloud banks of tradition with extreme slowness. In the United States, statutes and administrative rules, with a few notable exceptions, still refer to 'lunacy' or 'insanity,' and such time-honored expressions as 'keeper' for attendant and 'inmate discharged on parole' for tentatively discharged patient are widely used."

Dr. Goldmann feels, nevertheless, that "the extent to which specialized services have been developed is remarkable. So is the relatively short period of time that was needed to overcome the growing pains. Sixty-six special facilities for mental disease were in operation

in the United States by 1870. In 1942, nervous and mental hospitals registered by the American Medical Association numbered 586."

The present nation-wide discussion of the conditions existing in the public mental hospitals of the United States is reflected in Dr. Goldmann's study:

> "A considerable number of mental hospitals operated by public agencies rank high in quality. But there are also many institutions which are a disgrace to any community or government which calls itself civilized. Obsolete buildings, utterly insanitary conditions, a serious lack of competent nursing personnel, a paucity of psychiatrists, and a custodial atmosphere enveloping the whole institution are still frequently found. The history of mental hospitals is replete with instances where it took a scandal of major proportions to awaken public agencies to the need for drastic reforms."

In the opinion of Dr. Goldmann, a broad general planning program is imperatively needed. This also implies an over-all planning of health service in the widest sense of the term, including a broad and balanced program of medical care which must meet the individual's requirements as well as the community's need for adequate, humane, and economical service.

> "It must provide for all services needed by the apparently healthy, acutely sick, convalescent, and chronically ill, including care at the home, office, clinic, general hospital, special hospital, and custodial institution, in the amount and for the period required. It must apply to sickness, defect, injury, and maternity."

Planning for hospitals and related facilities makes necessary consideration of the following points: degree of concentration of hospital beds in large units and specialization of hospitals; quantitative and qualitative standards for the various types of hospital and related facilities; method of coördinating general and special hospital services; and the function of the medical center in the community health program.

Underlying all planning for adequate medical care must be a philosophy resting on two corner stones: society's need of the fit and productive individual and the individual's right to health. This concept recognizes the reciprocity of health and economy; the interdependence of the individual and the state, as well as their mutual obligations; and the need for social action substituting solidarity for isolated individual effort.

EMIL FRANKEL.

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STONE WALLS AND MEN. By Robert M. Lindner. New York: The Odyssey Press, 1946. 496 p.

This reviewer has a soft spot in his heart for the man who finds it possible to produce a book on a learned theme in English that can be understood by any one who will take the trouble to read it. The uninitiated will not require a glossary for *Stone Walls and Men,* although some of the terms that Lindner uses, when he undertakes to discuss the psychology of prison inmates, might cause an elevation of eyebrows here and there.

But these excursions can be discussed more adequately among the initiated. Our concern here is with a book—a gold mine of striking quotations such as the publishers reproduce on the back page of the cover—for the reader who is looking for a treatise on crime that will have the merit of simplicity and accuracy. One still hopes that such a book will be written. In part, Lindner has succeeded in producing it, but only in part—and possibly dangerously in places.

Dr. Lindner worked in the prison system in federal institutions, concededly the most humane of the American prisons. He finds that prisons have failed as rehabilitative agencies; that "they have been distracted by a delusion that they can cure criminosis and reduce crime by keeping people in air-conditioned zoos where they should be preventing criminals."

Long ago this reviewer asserted that he was not alone in the belief that there is no such thing as a good prison. Prisons fail of their function, and their shortcomings are legion. It would be a most fatuous individual who would claim that our prison system meets the needs of an enlightened social conscience. Nor would any one profess to believe that all institutions are generally humanely administered. What one reads in the press as to how the army conducted the Litchfield establishment is discouraging. Assuming the worst, however, it is an inescapable fact that the prisons of 1946 are infinitely more humane and preservative of the self-respect of their inmates than were the penal institutions of twenty, fifty, or a hundred years ago. In that, alone, is hope.

Dr. Lindner smiles at the lip service that is given in too many penal institutions to classification-board meetings and to the scientific apparatus and personnel that the penal systems have adopted. It is a rare warden who will whole-heartedly adopt the theories of the "long-hairs." Perhaps that, too, is as well. We know precious little about the science of human behavior, and what we do know is subject to modification as we learn more. There is nothing final about it. The genuinely fundamental quarrel that Lindner should

have, if he would strike at the root of the matter, is with the whole concept of punishment. Can fallible, weak, imperfect human being arrogate to themselves the function of God and punish other human beings who have been convicted of violations of the criminal codes?

Lindner quite properly devotes considerable space to the causes and conditions of political crimes. Here we are dealing with an area of conduct in which there is no unanimity of opinion. Is violation of the Selective Service Law an offense against the public decencies? Yet the community, for its own protection, is required to deal punitively with the people who disobey it. The conscientious objectors will not like Lindner's dismissal of them as potential homosexuals and sadists. Are the objectors criminals or criminotics, as Lindner likes to call them? What sort of rehabilitative therapy are we to apply to them? How are we to make them good citizens—which, in their case, means making good soldiers out of them?

For better or worse, we must have an army. An army requires men. If men will not come forward voluntarily, coercion must be applied to get them in. Nonconformity to the coercive measures will have to be made unattractive in order to prevent wholesale refusals to obey the public will. Thus far, the jail is the only answer we have available. It is not the perfect answer; it is not even a good answer; but in an imperfect state, it is the best means available for coercing the recalcitrant.

One suspects that this reasoning, with respect to so-called political offenders, can be carried over into areas of criminal behavior, wherein a greater degree of unanimity of opinion exists with regard to the necessity of inducing conformity in the socially maladjusted who take to crime. We are learning newer and better techniques—probation, for example—but we must still have coercive measures at the public disposal when other techniques fail. Because our prisons are inefficient agents for the elimination of crime, we cannot altogether abandon their use for the segregation of the criminally maladjusted. We still treat and alleviate diseases for which we have no knowledge of cause or cure. For some time to come, we will have to have prisons. The sooner we make them penal hospitals, conducted by scientists, guarded by men with sound scientific training, and geared to therapeutic rather than punitive processes, the better. But meanwhile. . . .

We should be thankful for the humanization of prisons; we should see to it that all our penal institutions are made humane by an aroused public conscience; and we should be satisfied with nothing less than the best available scientific equipment and personnel in

prison work. But there are humane men and women in the field of delinquency who are doing the best they can, within their limitations. One doubts that Dr. Lindner wants them to throw up their hands in despair and quit because prisons are not what they would have them.

The Lindner book will make some of us think; it will make some of us quite mad. It might even make some one go out and write a book to show that Lindner does not know what he is talking about. That is all to the good. Whatever else *Stone Walls and Men* may be, it is not insipid. It is well worth the reading, and it will have served a useful purpose if it turns out to be a springboard to start a great deal of discussion about a subject concerning which we need a wealth of informed opinion.

ALFRED A. GROSS.

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AROUND THE WORLD IN ST. PAUL. By Alice L. Sickels. Minneapolis: University of Minnesota Press, 1945. 262 p.

This is an account, vivid and colorful, of the folk festival held each year in St. Paul, Minnesota, as an effort to bring together and interpret to one another the various nationality groups in that Mid-Western city. These groups include the old-stock Americans, whose need for participation in such an effort is often not realized.

The festival had its beginning in 1938 in a tour of St. Paul, conducted by the International Institute. This agency, which is now at work in some forty American cities, was developed in 1911 by the National Young Women's Christian Association, as a service to foreign-born young women. "Most of the International Institutes have come of age, broken away from the parent organization, and become independent agencies." They are affiliated with national headquarters in New York City.

The 1930 census shows that St. Paul has at least twenty-five different national groups, the Swedish being the largest. The 150 persons who went on the tour mentioned above were so much impressed with the need for a better mutual knowledge and understanding among these many national groups that the idea of a folk festival was born then and there. It was later christened the "Festival of Nations," and was held six times during the years from 1932 to 1942.

The constant expansion of this festival makes a fascinating story. It began in the small Y.W.C.A. auditorium and grew year by year until it filled the largest auditorium in St. Paul, holding 3,300 people. This was filled to overflowing on each day of the festival.

It was not a money-making project, but always met its expenses, with something left over to start the next year.

Perhaps the most impressive paragraphs in the book are those that tell of the discussion that prefaced the 1942 festival: Should it be held, now that there was war? It was, and triumphantly.

Why this book is of interest to mental hygienists is well-stated by the author when she says (p. 23) that the purpose of the International Institute is "to restore a normal way of life to transplanted people"; and, again (p. 183), "The immigrants and their children too often have feelings of inferiority and shyness. Therefore, a relationship must be established and an opportunity offered in which they can, while remaining secure as a part of their own groups, participate in the larger community as givers rather than receivers."

This act of giving is emphasized again and again in the festival through the various kinds of beauty—in architecture, costumes, dances—contributed by the different national groups. Food also, which played a large part in the celebrations, was a form of contribution from each national group that could be easily understood and appreciated by all the others. The descriptions of these marvelous concoctions make the reader's mouth water!

Again, "the Festival put a value on difference and encouraged people to be themselves." There could be no better definition of mental hygiene in practice. Formerly, the idea of "Americanization" emphasized the giving up of old and cherished memories and customs and so becoming good Americans. This is pointed out to be the reverse of the truth. If backgrounds are made a source of pride, if national crafts are shown to be contributions of real value to one's adopted country, then those too frequent negative responses to the social isolation that often accompanies the immigrant into his new home—such as breakdowns in family and group controls, with their resulting delinquency—may never take place. American-born children may then take pride in the achievements of their parents, instead of being ashamed of them because they are "queer" or different. A new family solidarity appears, with all that that may mean in community life and citizen responsibility. Chapter VII, *Why Are You Doing This?* is full of illustrations of this sort of morale-building among recent—and not so recent—immigrants.

The last chapter, *America Is Only You and Me,* describes a plan for carrying on into the future this assimilation and recognition of new Americans—a folks art center, an international park and intercultural garden. This sounds ambitious, but no more so than the need is serious and extensive. The writer says (p. 247), "The psychiatrists have amply demonstrated that it is dangerous to cut one's self off from one's past, no matter how full of suffering it has

been." And the St. Paul Festival of Nations has amply demonstrated that each group has much to contribute to the enjoyment and understanding of every other. To expand one's sympathies, to bring hope and happiness out of loneliness and suffering, that is the truest proof of healthy emotional and spiritual growth.

ELEANOR HOPE JOHNSON.

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THEIR MOTHERS' SONS. By Edward A. Strecker, M.D. Philadelphia: J. B. Lippincott Company, 1946. 220 p.

A distinguished psychiatrist views with alarm the great amount of emotional immaturity that the Selective Service and the armed forces discovered during World War II—and writes of this in clear and, at times, really inspired manner. The body of the book sees the source of the trouble in our large number of selfish and oversolicitous mothers, but there are repeated hints that there are other sources of the difficulty—the "mom" is herself admitted "not to be of her own making"—and the fine sweep of the final chapter has scarcely a word on the rest of the volume. This last chapter can well stand in its own right, but I would have liked it better if Dr. Strecker had started with it and devoted the rest of the book to a development of its theme—our materialism.

There are nineteen other chapters, covering pretty thoroughly the gamut of the use of power to control rather than to develop people. The smothering mother was pretty thoroughly exploited during the first ten years of the child-guidance movement—though I can't remember any statement of that period that is as devastating and as well written up as is this. Also reminiscent of the twenties is this book's insistence upon emotional immaturity as the cause of most of our present ills. As Dr. Strecker uses it, the term is rather a shorthand term for those ills.

Chapter XV asks about those cultural factors which have produced "moms"—which soon turn out to be our sentimental attitude toward motherhood (in various places Dr. Strecker writes of mothers in a way that pulls at your heartstrings!) and progressive education. With just that innuendo that through the book he so rightly deplores, Dr. Strecker "wonders" how many rejectees of the last war were products of progressive education. If one were going in for that sort of thing, one might also "wonder" about the part that progressive education played in the miracle of a civilian army that stood up to the best that the professionals could produce.

The whole thing is meant as an indictment of those mothers who just can't give up the hold that the helplessness and dependence of

their children naturally gives to them. And it is so incisively written that you are likely to be caught in its compelling phrases. But Dr. Strecker would have done better to stay at the standpoint that at times he attains—that the selfishness and pathetic need of each of us —mother, father, teacher, daughter, nurse, son, clerk, lawyer, psychiatrist—for the praise and dependence of others terribly threatens the success of the national and international ventures upon which we are of necessity embarked.

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THE VETERAN AND HIS MARRIAGE. By John H. Mariano. New York: Council on Marriage Relations, 1945. 303 p.

This book concerns itself with a very serious problem facing our society to-day — namely, the ever-increasing divorce rate, particularly in relation to the veteran and his family. The book is addressed specifically to the veteran and orients itself around the question how he may best work out his own marital adjustment. The author accepts the veteran as a normal individual who needs no pampering or coddling, calling on him to spend his best efforts in sound, honest thinking about his marriage. It will succeed only if the veteran wills it so. This straight-from-the-shoulder method of talking to the veteran himself, instead of talking to every one else about him, is a very sound approach to the problem. The onus of salvaging his marriage is placed squarely on the broad shoulders of the veteran.

The first twenty chapters of the book deal almost entirely with the legal aspects of divorce and may well prove discouraging for the veteran who is not contemplating divorce, but is concerned primarily with making his marriage more satisfactory for himself and his wife. However, for those who are seriously considering divorce or separation as a way out, these chapters should prove exceedingly helpful. Hence, emphasis is placed on straight thinking and an avoidance of hasty decisions. The author feels that if there are children, they should be considered above either spouse. The veteran should seek sound legal and marital counseling, avoiding the untrained or unethical adviser. The final decision, however, must always be the veteran's.

There are two chapters, *Self Help in Marital Difficulties* and *How to Diagnose Your Marriage Problem,* which contain much constructive advice for all married couples, though again the emphasis is on those marriages that are approaching divorce. The veteran is urged to make an honest evaluation of himself in relation to his marriage — wherein he has failed it and wherein it has either failed or satisfied him. Suggestions are given for working out recurring difficulties and avoiding their repetition.

The last two chapters are a discussion of the veteran and his adjustment to his civilian job. The close interrelationship between job and marital adjustment is emphasized. The author would have the employer or personnel director take much more responsibility than is usual in helping the veteran with his marital adjustment. He would not have them become trained marriage counselors, but they should be aware when help is needed, how much they can give, and when professional advice is indicated.

The book emphasizes the difficulties the veteran is facing in his marriage. It shows that divorce in itself is packed with legal and emotional complications. It gives the veteran a set of rules and admonitions, "Do's and Don'ts" to follow in order that he may salvage his marriage, if he has the will to do so. Its subject matter, by its very nature, deals entirely with the unhappy aspects of marriage. However, it might have been helpful if the author could have included at least one chapter on what the veteran might hope to achieve for himself in contentment and well-being if he and his wife are able honestly to work through the major difficulties that are facing them in their post-war marital adjustment.

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PSYCHIATRIC INTERVIEWS WITH CHILDREN. Edited by Helen Leland Witmer. New York: The Commonwealth Fund, 1946. 443 p.

In the field of psychiatry, as in all other medical and social sciences concerned with individual and social pathologies, far greater progress has been made in accumulating and analysing data describing the problems, in ascertaining causative factors, and in making skilled diagnoses, than in the areas of effective treatment and prevention. In almost all training courses, the major emphasis is still placed on imparting the necessary background for orientation in the field and on the ability to analyze problems and their causes, rather than on the personal or social therapies required for the successful treatment or prevention of these maladies.

It can safely be said that the facilities for psychotherapy now available in the United States for the treatment of personality, behavior, and mental disorders are exceedingly small and utterly inadequate to the needs. Training in psychotherapy in grossly understaffed mental hospitals is difficult to obtain and is otherwise available only in a few scattered centers. Probably the majority of overworked psychiatric clinics still function largely on a diagnostic level because of pressures for service, the volume of work, limitations of staff, and the necessarily time-consuming aspects of psychotherapeutic procedures. The above publication will, therefore, be warmly welcomed

as a valuable contribution to psychiatric treatment in the child-guidance field.

In this book, ten treatment cases are presented by eight outstanding psychotherapists, who have had long training and experience in the study and treatment of problem children. The therapists represented are H. B. Moyle and Phyllis Blanchard, with two cases each, and Frederick H. Allen, Lydia N. G. Dawes, Hyman S. Lippman, Martha Macdonald, Beata Rank, and Robert A. Young with one case each. Five of the therapists are physicians, one is a child analyst, and two are doctors of philosophy in psychology and education. Six of the group have had Freudian analyses and all represent an interest in "dynamic psychiatry." The cases presented include six boys and four girls, ranging in age from five to seventeen years, with varied symptoms and backgrounds. The cases are grouped, with the first three classified as non-neurotic children, the next four showing neurotic symptoms, and the last three considered as seriously neurotic children.

The editor provides an introduction to the case records, which includes a summary of the evolution and nature of child guidance, a discussion and illustration of differential diagnosis and the concept of neurosis, and an analysis of what is involved in the therapist-patient relationship and its use for therapeutic ends. A bibliography is appended to each section. She briefly summarizes some generalizations on the cases presented and closes the book with a section entitled *Comments in Conclusion,*

In selecting the cases to present, the editor was handicapped by the fact that there were extremely few case records of child-guidance treatment available that were recorded in sufficient detail to make them helpful for the purpose either of clinical description or of research. Child-guidance psychiatrists "seldom record their work in great detail" and when they do, they are "inclined to emphasize the patient's mechanisms and actions rather than their own behavior."

The criteria that guided Miss Witmer's choice of available cases were as follows: They should be representative of child-guidance work and be fairly typical of child-guidance patients who were living with their parents; the therapy should follow upon diagnosis, should be theoretically based, and the case as a whole should carry conviction; the treatment should be at least fairly successful, attested to, if possible, by follow-up reports, and should illustrate as wide a representation of age, problem, and family situation as possible.

Each treatment case is preceded by general comments by the therapist, who presents something of his system of thought on psychotherapy and the frame of reference from which he approached his work with the child. As the case proceeds, the therapist also contributes footnotes to the text, in which he interprets the meaning

or purpose of the conversation or action described in the case narrative. The number of psychotherapeutic sessions with the children ranged from nine to fifty-three interviews. Although social workers were associated in the treatment of the cases, only very brief summaries of their work are given.

In six of the cases, the psychiatrist had at least one interview with one of the parents. In about half of the cases, there was "either little social work with the parents or work with them was not regarded as accomplishing very much." In some cases, "the clinic did not seem to put forth much effort toward engaging the parents in case-work," and in others, "it was apparently felt the work with parents was either not required or would be rather futile." Later follow-up reports are noted on a number of the cases.

As a result of her experience, the editor concludes that child-guidance practice "is not based on a single, well-integrated body of theory," and that "some of its divergences reflect only partly articulated differences in basic assumptions about human conduct." There are no "well-accepted catagories of either patients or treatment methods" and there is evidence of inexactness in the use of psychiatric terminology and "in the science of psychotherapy." The differences in approach "stem from the diversity of the children's problems and the therapists' own personality traits as well as from general theoretical conceptions."

The purpose of this volume is to "provide material of value to students and practitioners of psychiatry in perfecting their own techniques" and as an "incentive for psychiatrists to examine their work carefully and to become more alert to the meaning of their actions and those of their patients." In spite of this focus, the book will be of great interest and value to a wide variety of professional and lay groups interested in the treatment of problem children. Although it is hoped that many more volumes of full treatment cases will eventually be published, it seems likely that scientific progress in interviewing and treatment will be more rapid when libraries of cases mechanically recorded in full become available for study and analysis. It is promising that a beginning along this line seems to have been made by Carl R. Rogers in the recording of counseling interviews.

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NOTES AND COMMENTS

International Congress on Mental Health to be Held in London in 1948

The World Health Organization of the United Nations, in its constitution ratified by 63 nations, presents to world leaders in the field of mental health a great challenge and at the same time a serious responsibility in helping develop world policies for improved mental health. The first step toward meeting this responsibility was taken on May 12, when the World Federation for Mental Health was organized, with representatives present from England, Canada, and the United States.

At the First International Congress on Mental Hygiene, held in Washington in 1930, the International Committee for Mental Hygiene was organized. This organization sponsored a second mental-hygiene congress in Paris in 1937. Some months ago it was decided to reactivate the International Committee, so that it could coöperate with the World Health Organization and U.N.E.S.C.O. and help to make a success of the International Congress on Mental Health to be held in London, August 12-21, 1948.

In the process of reorganization of the International Committee, it was found that many of the officers and members of the governing board were no longer in favor with their governments. Others had died, and a number, including Drs. Adolf Meyer, William L. Russell, Augustus S. Knight, and Stephen P. Duggan, had presented their resignations, suggesting that younger men take their places.

Through the interest of the Josiah Macy, Jr. Foundation, Dr. J. R. Rees, Chairman of the International Congress on Mental Health to be held next year in London, was brought to the United States for the month of May. It was his suggestion that the name of the International Committee for Mental Hygiene be changed to the World Federation for Mental Health. At the meeting on May 12, he was elected President of the World Federation for Mental Health. Dr. Rees addressed the American Psychiatric Association annual meeting on the program and plans for the 1948 congress.

The Josiah Macy, Jr. Foundation called a meeting, on May 19, of representatives of about thirty national associations and professional organizations interested in the improvement of world mental health, to meet with Dr. Rees and discuss plans for making the 1948 London congress a success. This meeting was addressed by Dr. Brock Chisholm, Secretary of the Interim Commission, World Health Organiza-

tion, who outlined the need for a world federation for mental health to work with the World Health Organization. He stressed the desirability of having one accredited mental-health organization rather than different international groups representing all the various disciplines interested in improving world mental health. He stated that only one world organization in the mental-health field would be accredited.

At the meeting on May 12, new officers and members of the Interim Governing Board were elected, to serve only until the world meeting in London during August, 1948, when a truly world-wide governing board and officers will be elected.

An attempt was made to make the governing board representative of the many disciplines interested in improving world mental health by electing leaders from the fields of education, psychiatry, psychology, anthropology, psychosomatic medicine, psychoanalysis, penology, general medicine, and so on.

The following are officers and members of the Interim Governing Board of the World Federation for Mental Health:

Officers

Honorary President: Adolf Meyer, M. D., United States
President: John R. Rees, M.D., England
Vice Presidents: Frank Fremont-Smith, M.D., United States
Jean L'Hermitte, M.D., France
Auguste Ley, M.D., Belgium
Eugenio Medea, M.D., Italy
Jonathan C. Meakins, M.D., Canada
Henrique Roxo, M.D., Brazil
Secretary-General: H. Edmund Bullis, United States

These officers are *ex-officio* voting members of the governing board.

Members of Interim Governing Board

Binger, Carl A. L., M.D., United States
*Bouman, K. Herman, M.D., Netherlands
Brosin, Henry W., M.D., United States
Burlingame, Charles C., M.D., United States
*Charpentier, René, M.D., Monaco
*Evensen, Hans, M.D., Norway
Griffin, John D. M., M.D., Canada
Hargreaves, G. R., M.D., England
Harrower, Molly R., Ph.D., United States
*Henderson, D. K., M.D., Scotland
*Hesselgren, Kerstin, M.D., Sweden
*Hincks, C. M., M.D., Canada
Kenworthy, Marion E., M.D., United States
Kluckholn, Clyde, Ph.D., United States
*Komora, Paul O., United States
Levy, David M., M.D., United States
Line, William, Ph.D., Canada

MacCormick, Austin H., LL.D., United States
Mead, Margaret, Ph.D., United States
Mekeel, Scudder, Ph.D., United States
Menninger, William C., M.D., United States
Murray, John M., M.D., United States
Odlum, Doris M., M.D., England
*Potter, Howard W., M.D., United States
Prescott, Daniel A., Ed.D., United States
*Repond, André, M.D., Switzerland
*Ruggles, Arthur H., M.D., United States
Scoville, Mildred C., United States
Senn, Milton, M.D., United States
*Shaw, G. Howland, LL.D., United States
*Stevenson, George S., M.D., United States

*Elected previous to 1947.

The Executive Committee of the World Federation for Mental Health is as follows:

Frank Fremont-Smith, M.D., Chairman
H. Edmund Bullis
George S. Stevenson, M.D.
Molly R. Harrower, Ph.D.
Scudder Mekeel, Ph.D.

The secretariat of the World Federation for Mental Health will be located in the offices of The National Committee for Mental Hygiene, 1790 Broadway, New York, 19, N. Y., until the time of the London congress in 1948.

The main purposes of the London International Congress and the World Federation for Mental Health are:

I. To collect suggestions for improving world mental health from groups and individuals in all parts of the world
II. To analyze such suggestions by use of committees representative of the various cultures of the world as well as of the various disciplines within these cultures.
III. To make recommendations regarding these suggestions to the World Health Organization and U.N.E.S.C.O.
IV. To advise other national groups affiliated with the World Federation for Mental Health as to recommendations.

The 1948 London congress will not be like the former mental-hygiene congresses, as no individuals will deliver papers on their activities. Each presentation will be the findings of multi-discipline discussion groups. The great part of the work of the congress will be completed prior to the holding of the congress.

The unique method by which such work will be accomplished is through the appointment of preparatory commissions in all parts of the world. A preparatory commission is an informal discussion group, composed, it is suggested, of not less than five nor more than ten members, representative, where possible, of at least four different disciplines. Most of the preparatory commissions in the United States and Canada will be located in university centers and will meet informally over a period of months to discuss the subjects they select from the international congress agenda, which is devoted to mental health and world citizenship.

About twenty conveners — some psychiatrists, some anthropologists, some educators, some psychologists — have already agreed to call together preparatory commissions in their localities. Each preparatory commission will present from time to time, in the form of recommendations, the points of agreement reached on their phase of study. They will also present important points of disagreement.

These reports will be made in duplicate, the original going direct to the congress secretary, 39 Queen Anne Street, London W. 1., the copy going to World Federation on Mental Health, 1790 Broadway, New York 19, N. Y.

The recommendations of other preparatory commissions studying the same topics in other parts of the United States, Canada, England, Sweden, Switzerland, and so on, will be distributed to preparatory commissions.

The London congress committee will select certain preparatory-commission members in the United States to serve on international preparatory commissions, meeting during the London congress to discuss the same subjects. The resulting recommendations to the World Health Organization will be rather simple suggestions because of the compromises made. However, such recommendations, having been screened by representatives of different disciplines and of different nations, should be acceptable to the World Health Organization.

It is hoped that names of the conveners of preparatory commissions may be sent in from all parts of the country. Such coöperation will simplify the work of the executive committee. Suggestions for organizing preparatory commissions and lists of discussion subjects will be sent to any one interested.

H. Edmund Bullis, Secretary-General of the World Federation for Mental Health, will have in September complete congress travel information as to sailings and air schedules, together with rates for those interested. He has reserved a block of rooms in various London hotels and is arranging post-congress tours in the British Isles, Scandinavia, and Switzerland.

Annual Meeting of the American Psychiatric Association

Over 3,600 people attended the One Hundred and Third Annual Meeting of the American Psychiatric Association, which was held at the Hotel Pennsylvania, New York City, May 19-23. Among the 120 papers presented were reports on advances in such diverse fields as child psychiatry, brain surgery, convulsive disorders, shock therapy, alcoholism, and forensic psychiatry. There was a session on group therapy, one on military psychiatry, and one on psychiatric social service. A Veterans Administration symposium on the treatment of the hospitalized neuropsychiatric patient took up one session, and another was given up to the newly organized Psychiatric Foundation. There was also a joint session of the Section on Psychoanalysis and the American Psychoanalytic Association. The annual dinner was held on May 21, Dr. Samuel W. Hamilton, president of the association, presiding.

The Presidential Address was delivered by Dr. Hamilton at the opening session of the convention, on May 19. In it Dr. Hamilton urged the nation's psychiatrists to insist that the fundamentals of decent care be set up in all mental hospitals, "even if high standards of treatment have to wait for larger staffs." "Food and clothing, bathing facilities, a measure of privacy — particularly for women — all these topics and more need attention in the many institutions," he asserted.

Pointing to the food provided in mental hospitals as an example of inexcusable neglect, he attributed the crudities of preparation and service directly to the fact that allotted salaries are not high enough to attract competent cooks and dieticians.

He said further that thousands of our fellow citizens in mental hospitals are condemned to eating off battered aluminum dishes. "Thousands never have even a knife or fork . . . . because a great state is too poor to buy them — so it is said," asserted Dr. Hamilton. He disposed of the contention that patients might misuse table utensils by stating flatly, "In the hospitals where they are supplied, they are properly handled."

Unhappy stories about what befalls patients in mental hospitals are only part of the distressing situation due to inadequate funds, according to Dr. Hamilton.

"In some states, because of lack of beds, the old-age patients are not accepted in mental hospitals. Some of them go to jail, some are locked up in almshouses, and others are locked up at home. It is distressing to see this return of ancient abuses, and especially disquieting to those of us who thought they were out of date and abolished," he said.

Among the efforts that keep the situation from being entirely dark,

Dr. Hamilton described the participation of the federal government in the efforts of the American Psychiatric Association to develop better mental hospitals. Such efforts include the mental-hospital survey financed by the United States Public Health Service and conducted by the Mental Hygiene Division; chest surveys in mental hospitals as well as elsewhere, made possible through many state health departments by the Division of Tuberculosis Control; and the collaboration of the Division of Hospital Development, which has put an architect to work on mental-hospital construction problems. He also spoke of the efforts of The National Committee for Mental Hygiene to provide training for convalescent mental patients.

"Ahead stands our most important goal — better treatment . . . . for all patients who are mentally ill," Dr. Hamilton concluded. "Much of the treatment is done by physicians personally, much by our collaborators in nursing, psychology, and other skills, and much through community resources."

The officers of the association for the coming year are: President, Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital, Washington, D. C.; President-elect, Dr. William C. Menninger, Medical Director of the Menninger Sanitarium, Topeka, Kansas; Secretary, Dr. Leo Bartemeier, of Detroit, Michigan; and Treasurer, Dr. Howard W. Potter, professor of clinical psychiatry at the Long Island College of Medicine, Brooklyn, New York.

The next meeting of the association will be held in Portland, Oregon, May 9-14, 1948.

American Association on Mental Deficiency Holds Annual Meeting

The Seventy-first Annual Meeting of the American Association on Mental Deficiency was held in Saint Paul, Minnesota, May 28-31. It was attended by workers in the field of mental deficiency and allied fields from every section of the country, and the papers and discussions covered a wide range of topics, including medical, educational, administrative, social, and personal aspects of mental deficiency. One evening was devoted to a public meeting, at which Dr. Maurice Thomas, Director of the Rochester, Minnesota, schools, spoke on "Human Rights," and Dr. Edward J. Humphreys, Editor of the *Journal on Mental Deficiency*, on "Mental Deficiency." The Presidential Address was delivered at the "President's Dinner," by the outgoing president of the association, Dr. Warren G. Murray, Managing Officer of the Dixon State Hospital, Dixon, Illinois. There were two luncheon meetings, at one of which Dr. Donald Hastings, Head of the Department of Psychiatry and Neurology of the University of Minnesota Medical School, spoke on "Some Psychiatric Problems of Mental

Deficiency." The other was the regular annual luncheon of the association.

Among the papers presented was one by Dr. George S. Stevenson, Medical Director of The National Committee for Mental Hygiene. Entitled "Where and Whither in Mental Deficiency," it presented a somewhat gloomy view of the status of mental-deficiency work to-day as compared with twenty-five or thirty years ago, but Dr. Stevenson made it clear that he was criticizing the system and not its agents. The remedy, he felt, lies in a closer relationship between mental-deficiency work and other mental-hygiene activities in a broad community program.

The president of the association for the coming year will be Lloyd N. Yepsen, Ph.D., psychologist with the New Jersey State Department of Institutions and Agencies, Trenton, New Jersey.

National Conference of Social Work

For its Seventy-fourth Annual Meeting, the National Conference of Social Work met in San Francisco from April 13 to 19. The Mental Health Section of the conference, which was resumed last year after being discontinued during the war, was on the program again this year. Dr. Hyman S. Lippman, Director of the Amherst H. Wilder Child Guidance Clinic of St. Paul, Minnesota, served as chairman of the section, and Mrs. Kathleen O. Larkin, of Loyola University, Chicago, Illinois, as vice chairman.

The first session was held jointly with the American Association of Psychiatric Social Workers. Dr. Karl M.Bowman, professor of psychiatry at the University of California Medical School and Medical Director of the Langley Porter Clinic, of San Francisco, presided, and papers were presented by Dr. R. H. Felix, Chief of the Mental Hygiene Division, United States Public Health Service, and Daniel O'Keefe, Consultant in Psychiatric Social Work, United States Public Health Service. Dr. Felix spoke on "State Planning for Participation in the National Mental Health Act," and Mr. O'Keefe, on "New Frontiers in Psychiatric Social Work Under the New Mental Health Act."

Joint meetings were also held on later days — one with the Child Care Section, on "Temporary Residential Homes for Troubled Children"; and one with the Health Section, on "Implications of Psychosomatic Medicine in the Field of Social Work." Subjects discussed at other sessions included "Psychiatric Social Workers' Function in a General Hospital," "Mental Hygiene Factors in the Understanding and Treatment of Alcoholism," "Social Aspects of Epilepsy," and "A Social Program for State Mental Hospitals." A panel discussion, under the chairmanship of Dr. S. A. Szurek, Director of the Children's

Department of the Langley Porter Clinic, took up the question of the relation of social workers to psychiatry — how social agencies may use the services of the psychiatrist (1) for direct-treatment work, (2) for consultation and supervision, and (3) for an educational program.

Many of the programs of other sections and special groups were of mental-hygiene interest, notably those of the American Association of Psychiatric Social Workers and the American Association on Mental Deficiency, at one of the sessions of which Dr. George S. Stevenson, Medical Director of The National Committee for Mental Hygiene, spoke on "The National Mental Act as It Relates to the Mentally Deficient." Dr. Stevenson also acted as chairman at one of the sessions of the National Association of Training Schools, at which Dr. Kathleen K. Stewart, of San Francisco, spoke on "Psycho-dynamics of Frustration."

The 1948 meeting of the National Conference will be held in Atlantic City, New Jersey, during the week beginning April 19.

Second Coördinating Conference Held

Approximately 800 guests attended the sessions of the Second Annual Coördinating Conference, held April 10 and 11, 1947, at the Western State Psychiatric Institute and Clinic, Pittsburgh, Pennsylvania. The conference, intended to coördinate the concepts and services of psychiatry, psychiatric nursing, clinical psychology, and psychiatric social service, had as its theme "The Place of Psychiatry in General Medicine."

The first day was given over to a discussion of the principles and policies of the four disciplines. Participants included Raymond W. Waggoner, M.D., Ann Arbor, Michigan; Ralph Chambers, M.D., Taunton, Massachusetts; David Shakow, Ph.D., Chicago, Illinois; Miss Edith Beck, Topeka, Kansas; and George Preston, M.D., Baltimore, Maryland, who acted as coördinator of the points of view expressed. The individual and related importance of the aforementioned four fields was emphasized.

Winfred Overholser, M.D., of Washington, D.C., President-elect of the American Psychiatric Association, was the principal speaker at the dinner meeting, April 10, with William S. McEllroy, M.D., Dean of the School of Medicine, University of Pittsburgh, as discussant. Doctor Overholser's remarks were on the subject "Psychiatry and the General Hospital."

Attention the second day was directed to "Problems in Psychosomatic Medicine," with papers by O. Spurgeon English, M.D., Philadelphia, Pennsylvania; Harry M. Margolis, M.D., Pittsburgh; and John M. Johnston, M.D., also of Pittsburgh. Because of illness, Dr.

English could not attend in person and his paper was read by Dr. Campbell Moses, of Pittsburgh.

In the afternoon individual sessions were held with Thomas A. C. Rennie, M.D., New York City; Virginia Graham, Ph.D., Cincinnati, Ohio; Miss Eleanor Cockerill, Pittsburgh, Pennsylvania; and Miss Elizabeth Bixler, New Haven, Connecticut, who presided. Group discussions followed the presentation of papers with many local professional workers participating.

It is expected that the papers presented at the conference will later be published and thus made available to all who are interested.

Society for Research in Psychosomatic Problems Holds Annual Meeting

The Fourth Annual Meeting of the American Society for Research in Psychosomatic Problems took place in Atlantic City, May 3 and 4. The program included two sessions of papers and discussions on May 3 — one in the morning on "Psychosomatic Disorder of Muscles, Bones, and Joints," and one in the afternoon on "The Necessity for Reorientation in Medical Education from the Psychosomatic Point of View," and on "The Biological Interpretation of Vasodepressor Syncopy"; the annual dinner held that same evening; and, on May 4, a business meeting followed by a panel discussion on "The Contribution of the Psychologist to Psychiatric and Psychosomatic Problems."

The society was fortunate in having as one of its guest speakers, Dr. James L. Holliday, of Scotland. Dr. Holliday spoke on "Psychosomatic Medicine and the Problem of Rheumatism" at the morning session on May 3, and on "Psychosomatic Medicine and the Problems of Society" at the dinner meeting.

The 1948 meeting of the society will be held again at Haddon Hall, Atlantic City, on May 1 and 2.

American Occupational Therapy Association to Meet in October

The American Occupational Therapy Association is holding its national convention from October 31 to November 7, 1947, at the Hotel Del Coronado, across the bay from San Diego in California. This is the Thirtieth Anniversary of the association and it is making plans for the biggest and best convention it has ever held.

Dr. Samuel W. Hamilton Accepts Superintendency of Essex County (New Jersey) Hospital

Dr. Samuel W. Hamilton has accepted the position of Superintendent of the Essex County Hospital (for the mentally ill), at Overbrook, Cedar Grove, New Jersey, and will begin his new duties on

July 1, 1947. He succeeds Dr. Guy Payne, who is retiring after serving many years in that position.

Dr. Hamilton is well known to readers of MENTAL HYGIENE, having been associated with the activities of The National Committee for Mental Hygiene since 1917, as an Associate Medical Director, 1917-1922, in charge of surveys of state hospitals for the mentally ill and schools for the mentally deficient, and as Director, 1936-1939, of the Mental Hospital Survey Committee. (The National Committee was one of the eight medical and lay bodies of which that committee was composed.) With this group he made studies of the state institutions in practically every state in the country, and when the three-year period was ended, the continuation of the work was assumed by the United States Public Health Service (one of the eight bodies mentioned), and Dr. Hamilton was invited to join the service as Mental Hospital Adviser to the Division of Mental Hygiene, a position that he has held until the present time.

Dr. Hamilton was formerly a member of the New York state-hospital system, having served on the staffs of the Manhattan State Hospital and the Utica State Hospital. Later he was Director of the New York City Police Laboratory; Medical Director of the Philadelphia Hospital for Mental Diseases; and Assistant Medical Director of Bloomingdale Hospital, now known as the New York Hospital—Westchester Division. He was a major in World War I and served with the late Dr. Thomas W. Salmon, the first Medical Director of The National Committee for Mental Hygiene, in the American Expeditionary forces.

In 1933 Dr. Hamilton became acting director of the Committee's Division of Psychiatric Education and was engaged especially in preparing for the First Conference on Psychiatric Education, at which plans were formulated for the establishment of a board for the certification of psychiatrists and neurologists. As a result, the American Board of Psychiatry and Neurology was incorporated in October, 1934, with representation from the American Psychiatric Association, the American Neurological Association, and the Section on Nervous and Mental Diseases of the American Medical Association.

Dr. Hamilton is the retiring president of the American Psychiatric Association. He is an authority on mental-hospital construction and he has contributed many articles to lay and professional journals on this subject. In 1917, jointly with Mr. Roy Haber, he revised the "Summaries of Laws Relating to the Commitment and Care of the Insane in the United States"; and in the same year he also compiled the "Summaries of Laws Relating to the Feebleminded and the Epileptic." He was an adviser in the preparation of the 1941 edition of "Mental Hygiene Laws in Brief," also one of our publications.

Since 1922 he has been associated with The National Committee for Mental Hygiene on a voluntary basis as Director of the Division on Hospital Service.

Woods Schools Given to Corporation

Mrs. Mollie Woods Hare, founder and active head of the Woods Schools, Langhorne, Pennsylvania, has made an outright gift of the two and a half million dollar school property to a charitable corporation, to be known as the Woods Schools. The corporation is to be administered by a self-perpetuating board of trustees of between five and fifteen members. After the initial board of trustees is selected, neither the school management nor Mrs. Hare will have a ruling voice in the naming of their successors. The trustees will have the authority to elect all future members of the board.

The school was founded thirty-one years ago for the purpose of teaching the exceptional child — the child who, for whatever reason, does not fit into the usual educational program. Throughout its entire existence the school has concentrated on this field of education with consistently successful results. It has always maintained extremely small classes, so as to give personal attention to each student. For the last thirteen years it has conducted the internationally known Child Research Clinic, with an advisory board of outstanding medical and educational authorities. The clinic was founded in 1934 at the urgent requests of psychologists and educators that the findings of the Woods Schools relative to dealing with the exceptional child be made available both to the public and to scientific circles.

Mrs. Hare's gift of the Woods Schools will establish it as an outstanding non-profit institution in the field of special education in the United States. The gift will enable the school greatly to increase the scope of its operations. Scholarships will be provided for deserving children who, with two or three years of special training, can make normal adjustments and become more useful citizens. The work of the Child Research Clinic will be expanded so that its work will be of more widespread benefit.

Assistantships Offered by Temple University Reading Clinic

The assistantships listed below are available to students working toward master's and doctor's degrees in the Department of Psychology or in Teachers College, Temple University. Applications for these assistantships should be made to Dr. Emmett A. Betts, director of the reading clinic. An official transcript of undergraduate and graduate credits should be sent from each institution to Dean, Teachers College, Temple University, Philadelphia 22, Pennsylvania. A minimum of six semester hours of graduate work in the reading clinic is required

before the application is acted upon by the committee. Qualifications may be completed during the summer session.

Assistantships are available in each of the eight divisions of the reading clinic, depending upon the applicant's professional interest. For example, students majoring in clinical psychology may be interested in the reading analysis division or in the reading clinic laboratory school for dyslexias. Students majoring in education may be interested primarily in the corrective reading division and the developmental programs of the extension division. Emphasis may be placed at the elementary, the secondary, or the college level.

The stipends and salaries listed below are on a twelve-months basis. Vacations are granted during the regularly scheduled holidays for university employees. (In addition to the positions listed below are division supervisorships, etc.)

Rank	*Salary*	*Service*	*Privileges*
Associate supervisor	$1,800-$2,400	4/5 duties of full-time staff member	Registration for a maximum of five hours of graduate credit
Assistant supervisor	$1,200-$1,800	3/4 duties of full-time staff member	Registration for a maximum of seven hours of graduate credit
Senior remedial teachers, corrective teachers, clinicians	$960	25 hours each week	Registration for a maximum of nine hours of graduate credit
Junior remedial teachers, corrective teachers, clinicians	$600	18 hours each week	Registration for a maximum of eleven hours of graduate credit
Assistant remedial teachers, reading clinic technicians	$360	14 hours each week	Registration for a maximum of thirteen hours of graduate credit

The Annual Institute on Developmental Reading sponsored by the reading clinic was held this year June 23-27. The emphasis was on the *general-language* approach to the reading problem. Next year the *content* approach will be emphasized, and in 1949 the *semantic, or meaning,* approach.

Psychiatric-Nursing Seminar Held

On May 26, the New York State Department of Mental Hygiene opened a three-week seminar in Brooklyn for principals of schools of nursing and chief supervising nurses from the state's 26 mental institutions. Also in attendance were nurses who hold administrative and teaching positions in hospitals throughout the state that collab-

orate with the department in its educational program. The seminar was the first attempt in the history of the department to bring together a state-wide assembly of nursing personnel for such intensive training.

Headquarters for the seminar was the Brooklyn State Hospital. During the third week sessions were held at Letchworth Village, and Rockland, Central Islip, and Pilgrim state hospitals.

The aim of the seminar was to stimulate the state's administrative nurses and nurse educators to redefine the standards essential to an advanced program of patient care and nurse education, and to reëxamine their methods of achieving these standards; also to provide practical instruction in techniques for enlisting the enthusiasm of nurses and other ward personnel to work with intelligent appreciation, coöperation, and a progressive outlook.

Town Hall to Present Lectures on Modern Psychiatry

This fall Town Hall, New York City, is presenting a series of six lectures on Modern Psychiatry, to be given by Dr. Carl Binger, Dr. Franz Alexander, Dr. William Menninger, Dr. Roy R. Grinker, Dr. Thomas A. C. Rennie, and Dr. Brock Chisholm. The series will be given in the Town Hall auditorium, 123 West 43rd St., New York City at 5:30 p.m., on six consecutive Mondays, beginning October 20.

The course of lectures, which perhaps offers the most distinguished group of psychiatrists ever to appear on a single lecture series available to the general lay public, will be opened by Dr. Binger, who will speak on "What is Mental Health?" Listed in order of appearance will be Dr. Alexander, whose subject is "What is A Neurosis?"; Dr. Menninger, whose subject will be announced later; Dr. Grinker, speaking on "Psychology of Middle Aging"; Dr. Rennie, speaking on "What is Psychotherapy?"; and Dr. Chisholm, who concludes the series on November 24 with a talk on "Mental Health and International Relations."

The lecture course is being offered by the Town Hall Short Course Division, under the direction of Dr. Gregor Ziemer, Educational Director of Town Hall. Miss Isabel Leighton, member of the Town Hall board of trustees, is the course coördinator.

Helen Putnam Fellowship Awarded

The Helen Putnam Fellowship for Advanced Research in Genetics or in Mental Health has been awarded by Radcliffe College to Dr. Frances Jones Bonner, of Boston, for a second and final year. The announcement was made by President Wilbur K. Jordan at the commencement exercises on June 4.

Dr. Bonner was the first recipient of this fellowship, which carries a stipend of $2,000 and is open annually to a mature woman scholar

qualified to carry on significant research or creative work. Dr. Bonner secured her M.D. at the Boston University School of Medicine in December, 1943.

Dr. Bonner holds posts as assistant in neurology at the Harvard Medical School and research fellow in psychiatry at the Massachusetts General Hospital, in addition to appointments at the Children's Hospital and the Boston City Hospital. She will continue the research that she has been carrying on during the present academic year in the hereditary factors in hysteria.

"Psychiatric Aid of the Year" to Receive Award

The National Mental Health Foundation of Philadelphia announces an award of $500 to be made in the fall of 1947 to the man or woman employed as a psychiatric aid or attendant in a United States mental hospital who is judged to be worthy of the title, "The Psychiatric Aid of the Year," on the basis of the following qualifications: (1) skill, initiative, and imagination in the discharge of his or her duties; and (2) kindness and devotion to the patients in his or her care.

In addition to the award, the person chosen will be presented with an appropriate citation. Additional cash awards of $50 each and appropriate citations will be given to five nominees deemed worthy of honorable mention.

The purposes of the award are (1) to focus attention on the important rôle played by psychiatric aids and attendants in the care of the mentally ill; (2) to help gain prestige and dignity for those engaged in this profession; and (3) to encourage the promotion of higher standards of on-the-ward care.

Advisory Panel on Psychiatric Social Workers

An advisory panel on psychiatric social workers, consisting of five members, has been appointed to advise Mr. Daniel O'Keefe, Psychiatric Social Work Consultant, Mental Hygiene Division, United States Public Health Service, on such problems as personnel standards and methods of carrying out the provisions of the National Mental Health Act as they relate to psychiatric social work. Since the lack of trained psychiatric social workers is a major problem, policies concerning training will also be taken in consideration.

The members of this panel are: Miss Hester B. Crutcher, Director of Social Work, State Department of Mental Hygiene, Albany, N. Y.; Miss Almena Dawley, Assistant Director, Philadelphia Child Guidance Clinic; Mrs. Ethel L. Ginsburg, Consultant in Psychiatric Social Work, The National Committee for Mental Hygiene; Miss Ruth Smalley, Professor of Social Case Work, School of Applied Social Sciences, University of Pittsburgh; Miss Anna Belle Tracy, Professor of Psychiatric Social Work, School of Applied Social Sciences, Western Reserve University.

Yale Psychiatric Service Appreciated by Students

The following editorial from a recent issue of the *Yale Daily News* is encouraging evidence that the importance of a college psychiatric service is appreciated by the students themselves:

> "Yale Leads the Way
>
> "Everyone ventures to give advice to the young college man starting his four-year course of study. The minister and educator as well as the doctor or lawyer looks on himself as a leader in the community and, therefore, an expert on more affairs than seems to be justified by his title or training. Most of these people feel that they are exercising common sense, and that that is enough. Unfortunately 10 per cent of the average Yale class runs into difficulty that requires more than common sense to overcome, and it is the Psychiatric Service of the University Department of Health that provides this aid.
>
> "For over twenty years Yale has fostered the development of mental-hygiene service until today universities both at home and abroad turn to New Haven for advice and information before setting up similar services. Psychiatry, once a specialty practiced mainly in insane asylums, has come out into the life of the whole community. The principal interests of this service are not the spectacular or the startling cases which forms the basis of a Hollywood movie or a Broadway play, but the emotional and social problems of youth. No one has yet studied the complex problems of youth, but psychiatry offers not only a medical service, but a whole body of knowledge which will assist in meeting the physical, emotional, and intellectual challenges of coming to college.
>
> "The time to help the college student is in his freshmen year, at the beginning of his university career, before he has suffered the strain of any of a wide range of problems. Yale has already placed one hundred counselors, who live in close contact with the members of the freshmen class, in the position of advisers. But, aside from the knowledge of Yale which they were able to glean during their undergraduate years, these counselors have little more to base their advice upon than common sense. A series of lectures indoctrinating freshmen counselors with the general principles of psychiatry would do much to increase the value of their advice, for psychiatry, although lately arrived among the sciences, encompasses a province of ideas worthy of the responsibility of a university."

Significant Figures

The following figures, quoted from a recent news bulletin of the Illinois Society for Mental Hygiene, are of interest:

Last Year the Nation Spent

In gambling on sports	$15,000,000,000
For education	$2,500,000,000
For social security	$593,023,600
For slum clearance	$118,750,000
For cancer research	$4,832,000
For venereal-disease research	$1,000,000
For research on mental illness	$300,000

Recordings of "Inquiring Parent" Series Available

From November 1, 1946, to the end of April, 1947, Dr. Luther E. Woodward, Field Consultant of The National Committee for Mental Hygiene, conducted on WMCA in New York a weekly program of interest to parents and others concerned with child care and guidance. These fifteen-minute programs consist of interviews between the *Inquiring Parent* (rôle played by a professional actress or actor) and Dr. Woodward. The scripts were prepared by Dr. Woodward with the assistance, in certain research features, of Dr. Robert Goldenson, assistant professor of psychology at Hunter College.

Community Chests and Councils has selected the fourteen most popular programs in the series, and recordings for rebroadcast are being made and will be available for distribution in the early fall. These are "open end" recordings which permit the local announcer to make local tie-in with chests, councils, mental-hygiene societies, or other agencies in the community. Standard cue sheets will be prepared for the series. The program is considered suitable for sponsorship by child-welfare and family-welfare divisions of the Council of Social Agencies, by mental-hygiene societies, by groups of child-care agencies, or by the Community Chest as a public service.

The fourteen recordings, which may be presented in any order desired, include:

1. *Getting Along with Teen-Agers*
2. *Competition in the Family Group*
3. *How Important Is the Child's I. Q.*
4. *Young Children's Questions*
5. *Children's Dreams*
6. *Children's Companions*
7. *When Children Are Afraid*
8. *Growing Through Play*
9. *Authority in the Home*
10. *Family Size and Age Difference*
11. *When Children Are Jealous*
12. *Feeding Problems of Children*
13. *Why Some Children Become Delinquent*
14. *Children's Language*

Distribution of the series will be made exclusively through Community Chests and Councils, Inc., 155 East 44th Street, New York 17, N. Y. Priorities in any locality will be reserved for Chests and Councils within the period of three months from July 1. After that time Community Chests and Councils will be free to distribute the series to other organizations. Mental-hygiene societies or committees interested in this series should make arrangements through local chests and councils. No individual programs will be sold. To get one, the whole series must be purchased.

The price per set, including one set of scripts per order, ranges from $25.00 in cities whose chests raise less than $50,000 a year up to $75.00 in cities whose chests raise a million dollars or more. Local chests can supply more specific information. The full sets of seven platters — fourteen programs — will be ready for distribution September 1.

Radio Presentation of "A Pound of Prevention"

The New York State Committee on Mental Hygiene is pleased to announce that there will be a radio adaptation of the ideas expressed in *A Pound of Prevention,* the pamphlet by James L. Hymes, Jr., recently issued by the Teachers Service Committee on the Emotional Needs of Children, Caroline Zachry Institute, New York City.[1] Another and more popular medium of communication will thus be used to bring this material to a wide audience. The details are not yet available, but the Mutual Broadcasting System expects to broadcast the material early in September. Additional information will probably be available in midsummer, and those interested in advance publicity may communicate with Miss Elsie Dick, Educational Director, Mutual Broadcasting System, 1440 Broadway, New York City.

News of Mental-Hygiene Societies

Compiled by

Justin G. Reese

Field Representative, Division of State Mental Hygiene Organization, The National Committee for Mental Hygiene

Alabama

Newly elected officers of the Alabama Society for Mental Hygiene are: President, Mrs. Carol Forrest; Vice President, Miss Phyllis McCollum; Secretary-Treasurer, Miss Katherine Vickery.

At the annual meeting of the society, Dr. Frank J. O'Brien, of the New York City Public Schools, spoke on "The Value of a Mental-Hygiene Program to the Community."

California

Among its recent projects, The Mental Hygiene Society of Northern California has contributed active support to the passage of a new admissions bill, which provides for admission to mental hospitals by medical certification, as an alternative to the present civil-court procedure. In line with its program of preventive education, the society presented a series of five lectures on psychomatic medicine, conducted by recognized authorities in their separate fields. This series, with Dr. Langley Porter presiding, was enthusiastically received and well attended by both professional members and the laity. To further the interest in child development, four of the Northern California chapters showed the film, *This Is Robert,* after which Dr. Mary Alice Sarvis commented on specific aspects of the subject. In

[1]Reviewed in the April, 1947, issue of Mental Hygiene, pp. 297-98.

August the society is acting as one of the sponsors of the conference of the National Association for Nursery Education, which will be held in San Francisco. Representative speakers from this group are expected to meet with the chapters for discussions of community interest.

Connecticut

The Connecticut Society for Mental Hygiene held its Thirty-ninth Annual Meeting in New Haven on May 22, 1947, with over 250 people attending. Dr. Mary Fisher Langmuir, professor of child study at Vassar College, spoke on "How to Help Parents Understand Children's Needs."

The demand for help in planning study groups and lecture series for parents is growing steadily in Connecticut. In order to learn ways of meeting this, the society's executive secretary, Frances Hartshorne, has been given leave in July to attend the seminar on "Parent Education Leadership" at the Vassar Summer Institute.

Florida

The second mental-hygiene group in Florida in process of organization is the Southeast Florida Society for Mental Health. Initiated at the April meeting of the Florida State Conference of Social Work, a steering committee has been working on it, under Edgar A. Perretz, of the Dade County (Miami) Council of Social Agencies.

Georgia

Following the example of the citizens of Atlanta, who have their mental-hygiene committee, Savannah, under the leadership of J. S. Scarborough, Jr., of the Armstrong Junior College, organized its own group at a meeting held on June 23.

Hawaii

The Mental Hygiene Society of the Territory of Hawaii worked with the Territorial Hospital to obtain increased appropriations for the hospital through the 1947 legislature. A slight increase in the allowance per patient per diem was granted, plus an appropriation for additional buildings and a larger staff.

All members of the legislature have been placed on the society's mailing list to receive the quarterly news bulletin and other educational material in an effort to inform them about the work and objectives of the society, giving them a background of information that will help them to act on society-sponsored legislation presented to the 1949 legislature.

The research committee of the society has undertaken a survey of

mental-hygiene material available for use by students and teachers in public schools. From the survey they hope to develop practical material for general distribution to the schools. This committee during the past year made a survey of the problem of alcoholism in Honolulu, and published a pamphlet containing their findings. They advocate the establishment of a treatment center for alcoholics.

The society is assisting the territorial board of health in its efforts to obtain psychiatrists and psychiatric social workers for the mental-hygiene clinic and the child-guidance clinic.

Illinois

The Illinois Society for Mental Hygiene is concluding the intensive part of a special project for enlarging its public-education program and extending its base of operation. A prime factor in its drive are activities designed to secure higher appropriations from the General Assembly for operations of the state psychiatric facilities, particularly funds to bring salaries up to a level approximating that of the Veterans Administration. As this is written, bills are coming out of committees.

The society has drawn support for its program from leading civic, church, labor, business, veterans, professional, educational, and women's organizations. At one point the 1,250 member churches of the Chicago Church Federation devoted a Sunday to reading a manifesto from the pulpit on the need for improved psychiatric facilities.

The society has sent frequent brochures and mailings into every county of the state, has utilized a full-time speakers bureau, has used weekly programs on five major radio stations, and has maintained a representative in the state capitol.

At a special meeting, on June 2, of board members and professional and social-agency leaders, Dr. George S. Stevenson, Medical Director of The National Committee for Mental Hygiene, presented an address on "Mental Hygiene of the Future."

Iowa

Dr. Norman D. Render, Executive Director of the Iowa Society for Mental Hygiene, reports that the society's plans for the coming year were well launched at the executive committee meeting on June 12, in Des Moines. The increasing interest and participation of the lay public is represented in the trend toward lay offices shown by the election in April. The new president is Mr. King Palmer, of Des Moines, a former social-welfare director and prominent business man. One of the vice presidents, Mr. Irving W. Myers, is a well-known lawyer in Des Moines; and the treasurer, Mrs. Ray Mills, of Winterset, who is also to act as chairman of the publicity committee, is a housewife. Dr. Robert

S. Shane, of Pilot Mound, remains as chairman of the recruitment and conference committee, and a special committee, including the district mental-hygiene chairman of The American Legion Auxiliary group, was established to promote district meetings throughout the state. Dr. Herbert Merillat, Superintendent of The Retreat, a private mental institution in Des Moines, heads the legislation committee, and Dr. Wilbur Miller, Director of the Psychopathic Hospital at Iowa City, is chairman of the policy committee. Dr. Norman D. Render, Superintendent of the Clarinda State Hospital, remains as executive director.

The monthly news letter and pamphlet continues to bring in memberships, and the letters written by Dr. Robert Shane are arousing increasing favorable comment. A pamphlet entitled *The Minister and Mental Hygiene,* by Reverend Charles Kemp, of Red Oak, Iowa, a member of the society's executive committee, was distributed in May and has received much notice throughout the state.

Louisiana

According to an announcement by the governor, an additional mental hospital for the state of Louisiana will be constructed on the site of part of Fontainebleau Park, across Lake Pontchartrain from New Orleans. While the distance is fifty miles from the city, it is very difficult to find a location closer because of the peculiar terrain of the area. The psychiatric unit of Charity Hospital in New Orleans will be expanded to 200 beds. This unit, working with the new hospital across the lake, should render a service adequate for the immediate area it serves. The final decision concerning both the hospital and the psychiatric unit awaits the action of the board of liquidation. This expanded service has been an interest of the Louisiana Society for Mental Hygiene for seven years.

Massachusetts

At its annual public meeting, the Massachusetts Society for Mental Hygiene emphasized the importance of informing the people of the state about the mental-hospital situation. Mr. Richard Mackenzie, hospital consultant to the state departments of mental health and federal agencies, talked on the subject, "The Responsibility of the Citizen and the Community in the Care of the Mentally Sick." After pointing out the serious shortage of personnel, Mr. Mackenzie stressed the relationship between high-quality care of the mentally ill and wise economy of public funds. He outlined a comprehensive program for the state through which this high-quality care can be secured, to produce not only a higher percentage of cures, but much in the way of

prevention. Such a program calls for wide participation on the part of the people of the state, and the organization of regional or branch societies was recommended.

A one-day institute, on May 9, 1947, arranged by the Massachusetts Conference of Tuberculosis Secretaries and the Massachusetts Society for Mental Hygiene, discussed the mental-hygiene factors in the care and understanding of tuberculosis patients. The interest and enthusiastic participation of the large gathering again demonstrated how effectively interest can be stimulated by bringing mental hygiene into focus with special health and welfare problems.

Missouri

During the state Conference of Social Welfare held in St. Louis, April 23-25, the Missouri Association for Mental Hygiene sponsored a meeting, at which Dr. Rudolph Novick, Medical Director of the Illinois Society for Mental Hygiene, and Dr. Emmett F. Hoctor, Superintendent of the State Hospital at Farmington, Missouri, were the speakers. The three hundred people who attended showed marked interest in each speaker's approach to the total problem of maintaining good mental health and preventing mental illnesses.

Planning for the annual meeting to be held in the fall in Kansas City is under the leadership of Dr. G. Wilse Robinson, Jr., of Kansas City. At that time, in addition to a stimulating program, officers will be elected for the coming year. Until then the society's address will be 4500 West Pine Boulevard, St. Louis 8, Missouri.

New York

The New York City Committee on Mental Hygiene is continuing its work in three major areas:

1. Extension and improvement of out-patient service in mental hygiene. A study of four out-patient psychiatric clinics is being completed and is to be used as a basis for discussion with directors of psychiatric clinics on how psychiatric out-patient services may be improved and made more effective in New York City. Miss Winifred W. Arrington is in charge of this work.

2. Mental-health education is being carried on in two ways: by the development of new educational material, principally pamphlets, and through consultation on inclusion of mental-health material in other educational programs, including radio, plays, movies, the press, and magazines. Miss Nina Ridenour is educational secretary for the committee.

3. Information on resources for the care and treatment of the mentally handicapped and consultation on mental-health problems are

being given by a full-time information secretary, Miss Eleanor Barnes, who is on the staff of the organization.

The Mental Hygiene Association of Westchester County held its Second Annual Meeting on May 28, 1947. Dr. James M. Cunningham gave a talk on "Mental Hygiene as a Community Project" and the army film, *Let There Be Light,* was shown.

The association has been active in promoting the establishment of mental-hygiene clinics by the county department of public health. At the present writing, a clinic has been started in Yonkers, N. Y., and is functioning under the direction of a chief social worker, with a panel of local psychiatrists who will act until a full-time directing psychiatrist can be found.

The committee on alcoholism, coöperating with the New York School of Social Work, has sponsored a survey of the incidence of alcoholism in the county, and present methods of handling it. It will shortly be made available to committees of other interested organizations in the hope that it can be used as a basis for a coördinated program of action.

"Scientific and Social Aspects of Alcoholism" was the topic of a conference sponsored by the clergy committee, in White Plains, N. Y. on April 21. The principal speakers were Reverend Harry Emerson Fosdick; Reverend Seward Hiltner, of the Federal Council of Churches; Mrs. Marty Mann, of the National Committee on Education for Alcoholism Studies; Dr. E. M. Jellinek, of the Yale School of Alcoholic Studies; and Dr. John G. Lynn, of Grasslands Hospital.

On May 8 the nurses' committee sponsored a conference on "The Challenge of Mental Hygiene to the Nursing Profession." The speakers were Mr. Lawrence K. Frank, Director of the Caroline Zachry Institute of Human Development, N. Y.; and Dr. James M. Plant, Director of the Essex County Juvenile Clinic, Newark, New Jersey.

A radio series on mental hygiene is being prepared by the association in coöperation with the radio department of Briarcliff Junior College. These programs will be broadcast weekly over station WFAS, located in White Plains and broadcasting to the county.

A collection of books on mental hygiene, to be known as The Colegrove Memorial Library, was recently purchased. The fund for this purpose was donated by the family and friends of the association's first executive secretary, Mrs. Ruth Colegrove, who died in 1946.

At the annual meeting of the Mental Hygiene Society of Monroe County, held on June 17, Dr. Jennie D. Klein, chief attending psychiatrist at Meyer Memorial Hospital, Buffalo, and associate professor of psychiatry at the University of Buffalo, spoke on "Successful Family Living in Modern Society."

North Carolina

The Ninth Annual Meeting of the North Carolina Mental Hygiene Society was held in Asheville, April 28, in conjunction with the meeting of the North Carolina Conference for Social Service. Dr. Luther E. Woodward, of The National Committee for Mental Hygiene, spoke on "Mental Hygiene in Social Service," and Dr. Leslie B. Homan, of Duke University, author of *As The Twig Is Bent,* on "Combat Reactions of Veterans and Their Relation to Family Life."

At the business meeting that followed the program, Mr. Roy Eugene Brown, of Raleigh, was installed as new president of the society, succeeding Mrs. Ernest B. Hunter, of Charlotte.

Members who attended the meeting were entertained at tea by the staff of Highland Hospital.

Ohio

Announcement is made by the Cleveland Mental Hygiene Association of the appointment of Samuel Whitman to the post of executive director. Mr. Whitman comes to Cleveland from Michigan, where he was on the staff of the state department of mental health. A specialist in community education, Mr. Whitman did his graduate work at the New York School of Social Work and obtained his training in psychiatric social work at the Child Guidance Clinic of New York Neurological Institute. During the past seven years he has held positions as case-worker, case-work supervisor, and administrator in family service and psychiatric agencies. His most recent position has been that of supervisor in charge of the training of student psychiatric social workers at the Detroit Mental Hygiene Clinic of the Veterans Administration.

Oklahoma

Within the first week of its fund-raising drive, the Oklahoma Committee for Mental Hygiene secured $14,000 toward its $35,000 budget, mainly in $1,000 contributions, including one from Governor Roy Turner. Utilizing extensive newspaper space, editorials, and cartoons of *The Daily Oklahoman* and other newspapers, as well as several radio stations, the Oklahoma Committee is making the community conscious of citizen support for mental-hygiene activities.

With the legislative session over, the Oklahoma Committee points to unprecedented appropriations and the creation of a post of mental-hygiene commissioner for the state's psychiatric facilities.

The chairman of the Oklahoma Committee's drive is Reverend W. H. Alexander, noted radio pastor. The new executive secretary is Joseph K. Peaslee. Mr. Peaslee's first activity was to arrange a volunteer summer project at Norman State Hospital for psychology students at the University of Oklahoma.

Oregon

The Oregon Mental Hygiene Society held its Fifteenth Annual Meeting on May 22. The governor declared the week "Better Mental Health Week." The executive of the society was chosen as "Citizen of the Week," and her picture, with a statement about the society, appeared in every street car and bus.

During the week there were mental-hygiene window exhibits in five downtown Portland stores and in the public library. There were radio broadcasts and newspaper articles, not only in Portland, but in several out-state counties.

Approximately one hundred attended the annual dinner meeting. In addition to the necessary business, four persons, prominent in their respective fields, gave five-minute talks on mental hygiene in the home, the school, the church, and the court. The high light of the meeting was a playlet, *The Executive's Dream*. This was in rhyme, interpreting some of the problems and hopes of the executive. Many of these were introduced through "singing commercials" by three local high-school boys.

Much interest was aroused, resulting in an invitation to arrange two series of radio broadcasts on mental hygiene, many inquiries regarding the work of the society, and requests for personal service, as well as inquiries regarding the week's program, one of which came from Canada.

Pennsylvania

The House bill providing for a department of mental health in the state government of Pennsylvania was passed by the House last May, but the Senate Committee on Public Health and Welfare voted not to report out the bill. A hearing before this committee on June 3 brought out the fact that the State Medical Society of Pennsylvania was opposed to the bill as amended in the House. The Public Charities Association of Pennsylvania presented arguments for the passage of this bill and emphasized the need for a department of mental health in the state government, headed by a competent psychiatrist to supervise the expenditure of 82 million dollars appropriated by the present legislature for the mental institutions, in order to develop a program not only for the operation of the state mental institutions, but for a preventive program throughout the state as well.

A recent survey of the state mental institutions by the Public Charities Aid Association indicates the need not only to strengthen the program of treatment and care within the state institutions, but also the necessity for a careful analysis of the building program in order to spend most efficiently the appropriation for this purpose. The association believes that emphasis should be placed on the development of facilities for the treatment of new admissions, and recommends the

immediate construction of admission and treatment buildings in those institutions in which none now exists.

The personnel situation in mental institutions is not as acute as it was during the war, but there is still a dearth of physicians and other professional personnel, including nurses and occupational therapists. The lack of housing for professional personnel in some of the institutions is hindering the employment of some in this group. The question of a bonus pay to secure attendants in some of the critical areas is suggested in order that the state institutions can compete with local industries, particularly in the metropolitan areas. The situation regarding the employment of attendants for institutions in rural areas is improving.

Washington

The Washington Society for Mental Hygiene has secured additional funds through the Seattle-King County Community Chest and Council, to add an assistant executive director to the staff. This increase in personnel will enable the society to expand its program of state-wide development. Selection of the person to fill the job will be made in the near future.

Recent Appointments

Dr. John W. Ferree, formerly Director of the Division of Educational Services, American Social Hygiene Association, has been appointed Executive Director of the National Health Council, assuming the position on May 1.

In announcing the appointment, Mr. Philip Mather, of Boston, president of the council, stated that it is in line with the plans of the council to increase its services to local and state health councils. Working in close coöperation with Bailey B. Burritt, who was named executive director early this year, Dr. Ferree will be engaged principally in helping local, county, and state health councils broaden the scope of their usefulness, and in stimulating the formation of councils where their establishment would advance the effectiveness of community and state health agencies.

Dr. Gertrude L. Muller has been appointed Medical Director of the Providence Child Guidance Clinic, succeeding Dr. Temple Burling, who resigned last February. Dr. Muller had been a psychiatrist in the clinic for fourteen months prior to that time.

The conduct of the clinic remains the same under the new régime. There is an ever-increasing demand for the services of the clinic and in addition to the work carried on in the clinic itself, the members of the staff are frequently called upon to talk to various groups, such as Parent-Teacher organizations, hospitals, schools, and other agencies interested in the welfare of children.

New Publications

Under the title, *Mental Health Laws in Brief*, a series of compilations of state laws relating to mentally disordered persons is being prepared and issued coöperatively by The National Committee for Mental Hygiene and the National Mental Health Foundation, of Philadelphia. The laws include provisions with regard to the mentally ill, the mentally defective, epileptics, inebriates and drug addicts, and mentally ill and mentally defective offenders. The compilations for two states—Kansas and Pennsylvania—are now available. Copies may be obtained from The National Committee for Mental Hygiene at the price of $1.50 a copy.

A parent-education project that is receiving a good deal of attention is being conducted by the Louisiana Society for Mental Health in coöperation with the Louisiana State Department of Health. The project — which also has the backing during the first year of the Woman's Foundation, of New York City, and the George Davis Bivin Fund, of Cleveland, Ohio, — consists of the preparation of a series of mental-health pamphlets for distribution to the parents of all first-born children in the state of Louisiana, beginning with January, 1947. The plan is to prepare twelve of these pamphlets, one to be sent out every month during the child's first year of life. The State Department of Health of Louisiana is handling the distribution of the pamphlets, which are known as the "Pierre the Pelican" series.

Dr. Loyd W. Rowland, Director of the Louisiana Society, makes the first drafts of the pamphlets, which are then submitted for review to a group of critics made up of Miss Carmelita Janvier, Director of Special Services for the New Orleans Public Schools; Dr. Dorothy Seago, professor of psychology at Sophie Newcomb College, Tulane University; Dr. Charles Anderson Aldrich, of the Department of Pediatrics, the Mayo Clinic, Rochester, Minnesota; Dr. Milton Senn, senior assistant professor of clinical pediatrics, Cornell University Medical College; and Dr. Robert L. Sutherland, Director of the Hogg Foundation and professor of sociology, University of Texas.

Four of the pamphlets have already been issued—*Let Me Introduce Myself, Let's Talk Some More About the Baby, The Baby's Third Monthday Is Here*, and *Let's Talk About Talking*. A fifth — *My, How Time Flies!* — will be out shortly. They are written in lively, conversational style, in the simplest kind of language, with amusing little cuts interspersed through the text. At the end of each pamphlet is a "Quizette" of five or six simple questions dealing with the material in the pamphlet.

Copies of the pamphlets may be obtained from the Louisiana Society of Mental Health, 829 Hibernia Building, New Orleans 12,

Louisiana. Prices (subject to change if printing costs increase) are as follows: single copies 10 cents; 10 copies of any single issue, 50 cents; 50 copies any single issue $2.00; 100 copies of any single issue $3.75; one complete sample series $1.00.

Three papers on the general theme, "Developing Insight in Initial Interviews," have been issued in pamphlet form by the Family Service Association of America. The papers are *Guiding Principles Defined,* by Alice L. Voiland; *Guiding Principles Applied,* by Martha Lou Gundelach; and *Importance of the Initial Interview With the Unmarried Mother,* by Mildred Corner. Copies may be obtained from the Family Welfare Association of America, 122 East 22nd Street, New York 10, N. Y. at a price of 60 cents apiece.

The new and completely revised edition of the *Public Welfare Directory 1947* is now available. This directory is a complete guide for welfare workers. It includes listings of the personnel of federal, state, and local welfare agencies. Included also for each state is a statement on the administration of public assistance, information on interstate correspondence procedures, and the sources of vital statistics.

A statement on the disclosure of old-age and survivor's insurance information, tabular information on residence requirements for general assistance, and the categorical programs for each state, as well as a list of other directories available, are included in the appendix.

Copies may be obtained from the American Public Welfare Association, 1313 E. 60th St., Chicago 37, Illinois. Prices quoted are as follows: single copies, $1.80 each; 10 to 25 copies, $1.62 each; 25 or more copies, $1.44 each.

A new six-page leaflet entitled *Psychiatry,* by Florence L. Rome, has just been issued by Occupational Index, Inc., New York University, New York 3, N. Y. A thorough survey of the field, this pamphlet is now available for 25 cents, cash with order.

The leaflet gives information on the growth of psychiatry, future prospects, description of the work, qualifications and preparation necessary, methods of entrance and advancement, salary ranges, number and distribution of doctors already in the field, advantages and disadvantages. Sources of further information are listed, as well as selected references for additional reading.

First Sixteen Volumes of "Mental Hygiene" Available

A complete file of the first sixteen volumes of MENTAL HYGIENE is offered by Dr. R. F. Darnall, Superintendent of the Salasco Sanitarium School for Nervous and Retarded Children, Alexander, Arkansas. For details write direct to Dr. Darnall.

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